"CATCHING BABIES": IDENTITY AND LEGITIMATION IN MIDWIVES' WORK NARRATIVES

By

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This study is based on interviews with nurse-midwives and direct-entry midwives at various stages in their careers. Using narrative analysis, I focus on the stories that midwives tell about their work. I am concerned with the legitimizing discourses used by midwives to frame their identities in relation to their work, the medical community, and the public, because midwifery, like other professions at the margins of medicine, such as chiropractics, exists at the border of competing service claims.

I view each respondent as bringing to the interview her own particular biography, yet the stories she tells take place in relation to a particular set of discourses and their political, legal, and social environment. The environment in some ways "controls" the story that can be told, yet each woman exercises narrative agency in composing her own story. There is a tension here in which each woman's activity in composing a unique

narrative runs up against an environment of regulation and professionalization that tends to homogenize the stories. The very essence of midwifery requires a discourse of nature, of birth as a natural process. However, with increased standards for education and practice, a medical discourse now also shapes what stories can be told.

Much of the sociological writing on midwifery places it in opposition to a medical model. Traditionally the two are in opposition, yet when midwives talk about what they do, they cannot avoid the use of medical vocabulary. Their identities and the legitimation of their work are a complex configuration of stories told at the narrative intersection of nature and science, individualism and regulation, freedom and control, and empowerment and intervention.

CHAPTER 1
PROBLEM, BACKGROUND, AND KEY CONCEPTS

The following account of work life, told by a midwife, sets the tone for the narrative differences explored in this dissertation. The story presents in microcosm a larger tension in the midwifery community. The tension centers on the boundaries between different types of midwives and conceptions of midwifery. It is a tension involving the legitimacy of natural birth and the legitimacy of birth professionals.

> I think that the way nurse-midwifery is set up is flawed, in that, in order to have a physician, in order to practice outside of the hospital, let's assume a nurse-midwife wants to, which is a big assumption, we can talk about why that doesn't usually happen, but no, let's start at the beginning. We'll talk about their training. The majority, as you know, the majority of nurse-midwives are trained in university and hospital settings. I used to think that you could take someone like me and put me in a hospital-based educational program and I'd still come out being the same good midwife that I would have if you took me and put me in an apprenticeship or in an out-of-hospital focused program.
>
> I no longer believe that, because you know humans learn by observation and imitation, you know that's how we learn to walk, that's how we learn to talk, that's how we learn to parent, that's how we learn to *be* in our culture. There's no book of rules that says don't pick your nose in public, you know you pretty much figure that out, and you figure it out by watching people's reaction. I think where you're trained and how you're trained makes a huge difference on how you practice and where you're comfortable practicing and how you perceive birth . . . So that nurse-midwives tend to be very hospital oriented and traditional allopathic-medicine type of approach to birth. They're much more interventive than direct-entry, in my experience. However, I think that they are, they do "get it" better than the doctors. I think that a woman still gets more holistic care from a nurse-midwife than an obstetrician, but I think she gets even more

> holistic care from a [direct-entry midwife] than she would from the average nurse-midwife.
>
> So, sometimes I get very frustrated because I feel like nurse-midwifery practices take consumers who would be interested in the whole bag, the whole nine yards, you know normal birth, breastfeeding, all of the things that we imagine go along with that. And sadly I see those consumers steered into from the very beginning well you could have your baby at the birth center or you could have an epidural with a midwife in the hospital as if it were you know well, you can have a red apple or a green apple, you know and it's not, it's like you can have a pineapple or you can have a banana, they're very different. (Helen, empirically trained midwife)

In the story, the midwife presents herself and her identity as a "good midwife:"

> I used to think that you could take someone like me and put me in a hospital based educational program and I'd still come out being the same good midwife that I would have if you took me and put me in an apprenticeship or in an out of hospital focused program.

Although this is a story constructed by an individual midwife, the respondent uses the common legitimizing discourse of education to frame her contrasting identity as a different type of midwife: "I think where you're trained and how you're trained makes a huge difference on how you practice . . . and how you perceive birth."

The Problem

The problem with which this dissertation is concerned is the varied legitimizing discourses used by midwives to frame their identities, a sociological issue that is particularly important in the context of a profession, such as this one, that exists at the border of competing service claims. The leading research question is: What types of legitimizing discourses do midwives use to construct who they are in relation to their work, the medical community, and the public? But there is also a larger analytic issue at stake, representing a problem in discourse theory. The larger question is to what extent

do political/legal, regulatory, social/cultural, and historical conditions mediate the stories that can be told about experience, and to what extent do these women skillfully, artfully, and uniquely construct who they are in relation to their work despite the conditions?

Drawing on 26 in-depth interviews, I use narrative analysis to examine the stories that midwives tell about their work. I ask the women I interview to tell me the story of how they became a midwife, of their training and practice, and, when appropriate, the story of their life and work after they stopped practicing midwifery. Through these women's work narratives, I show the complex intersection of narrative, culture, institution, and biography (Chase 1995, 2001; DeVault 1999). Specifically, I focus on how they translate their experience into a narrative account, and how organizational and cultural contexts shape these accounts.

While each midwife brings biographical particulars to the interview, the story she tells unfolds within a specific historical, political, and social environment. The environment provides a communicative space in which the story can be told. This is not to say that an environment denies the artfulness of these respondents' narrative compositions; the environment does not totalize their stories, homogenizing beyond individual recognition. Rather, their varied skills at storytelling combine with the discursive mandates of medicalization, regulation, and professionalization, on the one hand and the sentiments of traditional midwifery on the other, to produce narrative complexity.

Background

Before I introduce the concepts of identity work and legitimizing discourses, let me provide a brief introduction to the profession of midwifery. Midwifery is the ancient practice of women attending other women in childbirth. Although widely practiced throughout the world, a burgeoning medical profession nearly eliminated midwifery in the United States in the late 19th century. The current climate for midwifery nationwide is ambiguous. While nurse-midwives practice legally in every state, direct-entry midwifery is illegal in many states. However, midwives from around the country are organized and pushing for professional recognition, licensure, and legal standing.

Definitions

In 1990, the International Confederation of Midwives (ICM), borrowing from and revising the World Health Organization's (WHO) 1965 definition of a midwife, wrote that

> A midwife is a person who, having been regularly admitted to a midwifery educational program duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.
>
> She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility, and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help.
>
> She has an important task in health counseling and education, not only for the woman, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynecology, family planning and child care. She may practice in hospitals, clinics, health units, domiciliary conditions, or in any other service. (cited in Rooks 1997:6)

Primarily, two different types of midwives practice in the State of Florida, where this study was conducted: direct-entry, licensed midwives (LM) and certified nurse-midwives (CNM). *Certified nurse-midwives* have a bachelor's degree in nursing and a master's degree in midwifery. In Florida there are three nurse-midwifery programs, one at the University of Florida, one at the University of South Florida, and one at the University of Miami. The training of CNMs typically takes place in a hospital setting, and the majority practice in a hospital setting, although some practice in freestanding birth centers. In the State of Florida, CNMs are licensed as Advanced Registered Nurse Practitioners (ARNP). This provides them with the professional capacity to prescribe medicine and provide well-woman care. CNMs must work under the supervision of a physician. There are currently more than 500 CNMs registered in the State of Florida (American College of Nurse Midwives 2000).

The term *direct-entry* is taken from the European model of midwifery in which the midwife enters directly into practice without first becoming a nurse. In Florida, direct-entry midwives are licensed under the Midwifery Practice Act (Chapter 467 F.S.), and are called "licensed midwives" (LM). Since 1992, the requirements for student midwives include three years of intense academic and clinical training based on core competencies established by the Midwives Alliance of North America (MANA) and the American College of Nurse Midwives (ACNM). Licensed midwives may provide care for women with normal, low-risk pregnancies in a variety of settings, including hospitals, birth centers, and clients' homes, although in Florida, very few LMs practice in hospitals.

There are currently more than 80 LMs in the State of Florida (Midwives Alliance of North America 1999c).

At times, I will refer to *empirically-trained* midwives. These are women who practiced midwifery in the underground movement of the 1960s and 1970s. Their training was based on an apprenticeship model in which learning takes place on the job from a skilled practitioner. The empirically-trained midwives that I interviewed for this project, for various reasons, chose not to become licensed, but continue to be vital participants in the midwifery community. I will use the term "empirical" when referring only to empirically trained midwives and the term "direct-entry" when referring to both licensed midwives and empirically trained midwives.

Florida is one of the most progressive states in terms of direct-entry midwifery education, licensure, and regulation. The state has had licensing requirements for direct-entry midwives since 1931. With a resurgence of interest in midwifery and home birth in the 1960s and 1970s, the state revised its Midwifery Practice Act in 1982. Two years later, the Meyers Act placed restrictions on licensing. Finally, in 1992, under the leadership of the late Governor Lawton Chiles, the Midwifery Practice act was revised again and licensing of direct-entry midwives reopened in October 1992. Based on the distinctive political, social, and legal climate surrounding midwifery in Florida, the state is a relatively unique environment in which to conduct the present research.

Key Concepts

Several key concepts surround the analysis of respondents' narratives. All of these bear on the relationship between personal narratives, identity, and broader social discourses.

Identity Work

The academic literature on identities is extensive. Disciplines such as literary criticism, psychology, sociology, and cultural theory seem enamored with theorizing about identity. The most current and cutting edge discussions of identity focus on the intersections of gender, sexualities, class, and race, ethnicities, and nationalities (see Anzaldua 1987; Broad 2000, forthcoming, in press; Butler 1990; Connell 1995; Crawley 2001; Esterberg 1997; Halberstam 1998; Haraway 1991; Minh-ha 1989; Phelan 1994; Seidman 1997; West 1993).

Social psychology especially has a long legacy of interest in the self and identity. Rosenberg (1987) has identified at least ten different ways that scholars have used the concept of identity. These include a sense of oneself as continuous and existing through time; distinctiveness, uniqueness or separateness; a sense of oneself as belonging to a group or having shared group membership; social role configurations; authenticity, essence or real self; situational roles; efficacy, volition or personal agency; stability of values and sense of life meaning; self-conception; and the distinguishing character of an individual. Here, I conceptualize identity, in part, as the presentation of self within the confines of community, emphasizing the work that is done in designating who and what one is. However, it is important that we also think about identity as situational, shifting,

and constructed. The concept of "identity work" highlights the creation of meaning from, and in relation to, existing social categories.

Gleason (1983) notes that social science research on identity originated from two streams of thought, one a "psychological social psychology" and the other a "sociological social psychology." One school of thought follows a psychological model of identity development proposed by Erik Erikson (1959). Erikson's model includes a series of identity crises that must be resolved at each developmental stage. This process leads to the development of a stable sense of a core self within a social context.

Using a sociological lens, narratives of identity and self have focused not on the inner life of a self, but rather on the social construction and social components of identity. In the tradition of James (1961(1892)), Cooley (1964(1902)), Mead (1934), and Blumer (1969), identity relates to a social self, located in the interaction between individual and society. For some symbolic interactionists and role theorists, identities refer to names or labels that individuals attach to social positions or roles that carry expectations for particular types of behavior (Stryker 1980; Burke and Franzoi 1988; Burke and Tully 1977). For others, such as Erving Goffman (1959), the self is negotiated in particular social settings with particular audiences, stressing, as this dissertation does, the active formation of the identities in question.

Collective Identity and Boundary Work

New social movements theory focuses attention on collective identity and boundary maintenance (Eyerman and Jamison 1991; Gamson 1995; Gamson 1997; Johnston et al. 1994; Melucci 1995; Taylor and Whittier 1992, 1995). Johnston et al.

(1994) distinguish between individual identity, collective identity, and public identity in the context of social movements. Individual identity refers to individual biography constructed through social interaction. Collective identity is a result of a process of negotiation about an "agreed upon definition of membership, boundaries, and activities for the group" (p. 15). Collective identity influences individual identity to the extent that group definitions affect how an individual thinks about his or her self. Public identity refers to the fact that individual and collective identities are influenced by the perceptions of the general public, state agencies, other organizations, and the media. All of these bear on this dissertation as the midwives' identity work is not considered in isolation, but in relation to public and shared identity discourses.

Taylor and Whittier (1992) outline three elements of collective identity: boundaries, consciousness, and negotiation. Boundaries are established when individuals identify with the shared characteristics of a group. Johnston et al. (1994) explain that "boundaries can be thought of as activities and definitions that reinforce the we-they distinctions, which are often marked by differences in physical appearance, speech, demeanor, and other behaviors" (p. 20). Once boundaries are formed, a group consciousness must be developed to give meaning to the collective. This is often established and communicated through writings, speeches, and documents, but is woven into the everyday lives of participants. The concept of negotiation involves the ways in which members of the collective resist negative definitions and work to establish and disseminate positive definitions of the group. Taylor and Whittier (1992), building on the

work of Margolis (1985), outline two types of negotiation vital to the construction of collective identities:

> First, groups negotiate new ways of thinking and acting in *private* settings with other members of the collectivity, as well as in *public* settings before a larger audience. Second, identity negotiations can be *explicit,* involving open and direct attempts to free the group from dominant representations, or *implicit*, consisting of what Margolis terms a "condensed symbol or display" that undermines the status quo. (Taylor and Whittier 1992:118)

While much discussion of boundary maintenance emerges in the social movements literature, there is also an extensive discussion of boundary maintenance and "boundary work" in the literature of work and occupations, particularly in the health professions. Gieryn (1983, 1999) discusses the boundary-work of scientists, contrasting their work to non-science in an attempt to legitimate claims of authority. Other studies show the boundary work of clinical pharmacists (Birenbaum 1982; Mesler 1991), public-health nutritionists (DeVault 1995), homeopaths (Cant and Sharma 1996), psychiatrists (Williams and Luterbach 1976), and nurses (Allen 1997, 2000, 2001; Beardwood 1999; Wicks 1998), all of which relate to the health-related identity work of the midwives studied.

Biographical Work and Social Construction of Self

Scholars of narrative and the life course argue that the life story *is* identity (Foley and Faircloth 2000; Gearing 1999; Giddens 1991; Gubrium and Holstein 1995; Holstein and Gubrium 2000b; McAdams 1993). Throughout the life course, individuals craft and re-craft a life story, incorporating new events in a way that gives coherence and meaning to their experiences, constructing their identities. As Anthony Giddens (1991) argues:

> Self-identity is not a distinctive trait, or even a collection of traits, possessed by the individual. It is the self as reflexively understood in terms of her or his biography . . . The existential question of self-identity is bound up with the fragile nature of the biography which the individual "supplies" about herself. A person's identity is not to be found in behaviour, nor - important though it is--in the reaction of others, but in the capacity to keep a narrative going. The individual's biography, if she is to maintain regular interaction with others in the day-to-day world, cannot be wholly fictive. It must continually integrate events which occur in the external world, and sort them into the ongoing "story" about the self. (p. 53-54)

Holstein and Gubrium (2000b) assert that individuals engage in *biographical work* to assemble and manage consistency and continuity in the telling of a life story, "assuring that the past reasonably leads up to the present to form a life line" (p. 155). While some ethnographers and qualitative researchers are concerned with the "authentic voice" of the subject, an interpretive approach seeks to uncover how the seeming coherence of stories is accomplished in the telling (Gubrium and Holstein 1998). Denzin (1996) describes this tension this way:

> The point to make is not whether biographical coherence is an illusion or reality. Rather, what must be established is *how* individuals give coherence to their lives when they write or talk self-autobiographies. The sources of this coherence, the narratives that lie behind them, and the larger ideologies that structure them must be uncovered. (p. 62)

In *The Self We Live By,* Holstein and Gubrium (2000a) continue to flesh out the narrative construction of self. Arguing that people use biographical particulars as resources in self construction, the authors expand and claim that these resources are "used circumstantially, identified and descriptively mobilized to become part of local selves-in-the-making" (p. 169). The self is not merely a reflection of how we think others perceive us; instead we are active creators of multiple social selves. Yet our stories of self must be

believable and accountable in a particular local culture. Local understandings condition, but do not determine, how we present ourselves and what identities we choose to put forth, one of the leading themes of this dissertation.

Legitimizing Discourses

From a postmodern perspective, it is important to note the decline of the legitimating power of grand narratives, such as the foundational position of science for example (Lyotard 1984). Habermas (1975) speaks of legitimations as ideas produced by the political system to justify its continued existence. In describing systems of domination, Weber (1958/1919) also explains that these systems make every effort to authenticate and encourage the belief in their legitimacy. Theoretically, we can think of legitimations beyond the political system as ideas produced by any system to support its own existence or belief in its own legitimacy. Berger and Luckman (1966) explain the process by which legitimations are transmitted to the next generation in the following way.

> The same story, so to speak, must be told to all the children. It follows that the expanding institutional order develops a corresponding canopy of legitimations, stretching over it a protective cover of both cognitive and normative interpretation. (p. 62)

The midwives in this study engage various discourses, or a "canopy of legitimations," which are discussed in Chapter Three, to legitimize or justify their existence.

Narrative Practice

My research employs a social constructionist perspective, informed by both Foucauldian discourse analysis and ethnomethodology. Combining these two approaches allows for the examination of both the *hows* and the *whats* of the construction process.

Foucauldian analysis points toward the *whats* of discourse. Ethnomethodology focuses on *how* things are practically articulated through talk and interaction (Garfinkel 1967). I am especially concerned with what Foucault (1977) terms the "conditions of possibility" for reality construction. In other words, *what* interpretive resources are made available, what vocabulary is used, when a particular vocabulary is used, in what circumstances, to what audiences, and with what implications. But Foucault's perspective tends to overlook the artful side of discursive activity. I am also concerned with *how* the midwives use available interpretive resources as sense-making devices for constructing identities in relation to midwifery (Gubrium and Holstein 1997; Miller 1997), as these are articulated in relation to the conditions of possibility presented by the midwifery discourses in question.

Foucault uses the term "discourse" in three ways, conceptualizing it at a wider, structural level, an individual level, and, lastly, as a regulatory agent. He writes:

> Instead of gradually reducing the rather fluctuating meaning of the word 'discourse,' I believe I have in fact added to its meanings: treating it sometimes as the general domain of all statements, sometimes as an individualizable group of statements, and sometimes as a regulated practice that accounts for a number of statements. (Foucault 1972:80)

Here I am concerned especially with the last two meanings that Foucault gives to the term. Using his second meaning, a discourse as an individualizable group of statements, or statements that are regulated in some way and have some coherence to them, we can think of discourses of femininity, discourses of nature, etc. When Foucault speaks of discourse as "regulated practice that accounts for a number of statements," he is concerned with the

rules and structures that produce various discourses (Mills 1997). In the context of this project, the former sense of discourse relates to the wider cultural discourses available for meaning making. The latter sense of discourse is what I refer to as the "narrative environment," or the history, politics, regulations, and cultural practices that produce particular discourses and forms of knowledge.

A Foucauldian perspective attends to the conditions of possibility for these practices. The leading question here is, what discourses are historically and institutionally available to be used by the respondents and how do they use them in practice? While there are many available discourses, not all of them enter into usage when identity becomes a topic. Midwives choose from what is available. However, they do not choose arbitrarily, because there are always local, institutional, situational and biographical auspices at play to guide them.

Borrowing from ethnomethodology, I am concerned with the way in which the respondents construct their social world through talk. Ethnomethodology has been described as an *analytics* of discursive practice (Holstein and Gubrium 2000a). The focus here is on the process of construction. Clifford Geertz (1973) describes this as looking at how members of society work at "spinning the webs of significance in which they themselves are suspended" (p. 5). Geertz's description reminds us that, from an ethnomethodological perspective, we are interested in the process of spinning, rather than in the patterns that make up the finished product.

In this study, I focus on both *what* midwives have to say and on *how* they tell their stories. Several important questions result: What resources are available within the

historical, political, and social environment for women to draw upon in telling their stories? Do they rely on medical discourses, feminist discourses, discourses of professionalization, discourses of nature, discourses of science, or other available discourses in their identity work? In what contexts and to which audiences might they use each of these?

The very essence of midwifery requires a discourse of nature, of birth as a natural process. However, with increased standards for education and practice, a medical discourse now provides the discursive conditions for storytelling. Much of the social science and feminist writing on midwifery places the two in opposition to each other (for exceptions, see Annandale 1988; Annandale and Clark 1997; Davis-Floyd et al. forthcoming 2002). Yet when midwives talk about their work, they do not avoid the use of medical vocabulary. In place is a narrative tension in their storytelling, winding its way between nature and science, individualism and regulation, freedom and control, and empowerment and intervention.

I am also interested in *how* various types of midwives construct the agents of their work, including the woman, the child, the birth process, themselves, and other birth professionals. While the midwives I have spoken with seem to maintain the ideal of choice in childbirth and see their role, broadly, as empowering women to trust their bodies, the specifics of their idealism and perception of their own role in birth take different forms. Direct-entry midwives and nurse-midwives construct each other in a way that communicates the professional boundaries between them. Midwives construct the role of doctors and traditional medicine differently, based on their own professional demands. As

will be shown, identity work does not stand on its own, nor are the identities produced articulated in isolation from one another.

The narrative environment in which my respondents interact consists of certain histories, politics, regulations, and social contexts that to some extent dictate what the respondents can tell. The environment is one that tends to homogenize the stories that are told, reproducing specific discourses in the process. These discourses provide the women with resources for the artful construction of self, which come forth in the interviews.

Such environments cannot be ignored in the analysis of narrative. My project extends beyond just the stories. Other researchers acknowledge the mediation of available narrative forms (Riessman 1990, 1993; Ochberg 1994), such as the wider cultural discourses in place (Chase 1995), yet privilege the story or stories. For example, Chase (1995) illustrates the use of wider cultural discourses of individual achievement and of inequality by African American and Latina women school superintendents. I am concerned with wider cultural discourses, but also wish to seriously emphasize how the narrative environment shapes stories. This narrative environment involves more than just wider cultural discourses, including specific and practical institutional and organizational constraints.

Rationalization and Professionalization

This project is situated in a particular professional environment made up of various legitimizing discourses and discursive practices. In Chapter Three, I outline the historical, legal/political, regulatory, and social/cultural conditions currently informing midwifery practice. Taken together, these point the profession toward increasing standardization and

rationalization. In this context, adapting a Weberian notion of rationalization, I argue that while this process conditions the way stories can be told, it does not provide the full picture, dismissing individual agency and constructing the storyteller as a communicative puppet. It ignores the practical actor or storyteller who creatively makes use of various discourses to tell her story in a manner that conveys a coherent meaning for her professional activities.

Weber (1921) distinguishes between several types of rationality: practical, theoretical, substantive, and formal. He argues that in the process of modernization, institutions and bureaucracies within institutions "advance" from practical, through theoretical and substantive, to formal rationality. Here, I am interested in the process of formal rationality and its tension with substantive rationality. Each of these forms of rationality involves a means-to-end calculation, however they are embedded in different contexts. The context of formal rationality is one of rules, laws, and regulations that are universally applied. Substantive rationality, on the other hand, involves choice within a specific system of values.

We see a tension between formal and substantive rationality in the practical talk of midwives. At times they draw upon a discourse of standardization and efficiency, in particular, to frame their work in terms of general rules and regulations. At other times, they call upon women's intuition, primal feelings, for example, and make sense of their work within that particular system of values (Davis-Floyd and Davis 1997). They use various discourses to give meaning to the work they do. As such, rationalization is not something that generally drives these narratives, as Weber would have it, but something

they occasionally *use* to make sense of who they are and what their profession has become.

More recently, Ritzer (1996, 1999) outlines four characteristics of formal rationality that institutions and bureaucracies exhibit. The first characteristic, calculability, is the desire or need to count and quantify. Second, efficiency refers to finding the best and typically the fastest means to an end. Third, predictability assures that things will happen in the same way regardless of time or location. Finally, agencies and institutions will seek control over uncertainties, perhaps most notably over human beings. Ritzer argues that this process of rationalization often has irrational consequences for the individuals involved, for the systems themselves, and for society as a whole. Weber refers to this irrationality of rationality as an "iron cage." While Weber is critical of this process of rationalization, he sees it as the inevitable end of modernization.

Midwifery is currently in the process of professionalization. Direct-entry midwifery is following a similar path paved by nurse-midwifery in the 1970s and 1980s. In a later chapter, I outline the path taken by each of these emerging "professions." For now, it is sufficient to note that the development of schools and educational programs, licensing requirements, and national organizations are all consequential steps toward the monopolization of knowledge that "professions" dictate.

This points to Ritzer's characteristics of rationality. The standardization of the education and practice of midwives is now calculable. Through registration and licensure one can count exactly how many midwives are practicing. Indeed, one can count the number of midwives practicing in specific hospitals, birth centers, and home birth

practices. The push toward requiring midwives in each state to pass the same examinations, have the same educational requirements, and provide the same scope of practice has led to a high degree of predictability. National associations and accreditation agencies have further increased efficiency. Finally, with increased state and federal regulations on midwifery practice, the work of midwives will be further scrutinized and confined within institutional frameworks.

If we look at the historical, political, legal, regulatory, and social climate surrounding midwifery, it seems as though a process of rationalization is in place in the standardization of the profession. However, this argument is problematized if we shift from Weber's concept of rationalization to the more discursive view of Michel Foucault. Foucault argues, in contrast to Weber, that there are multiple processes of rationalization and multiple positions from which to rationalize (Dean 1994) and, what is more, that there is always resistance to this process (Foucault 1978). As this dissertation will show, rationalization is actively attended to, not merely passively drawn from, in the midwives' narratives.

Outline of the Study

The dissertation is organized the following way. In Chapter Two, I discuss the respondents and the interview questions, give an ethnographic description of the community, and detail my methods of analysis. Chapter Three provides an outline of various legitimizing discourses in place for these women: historical/traditional, activist, political, legal, educational, professional, medical, social/cultural, scientific, feminist, natural, and spiritual.

Chapters Four through Seven are substantive, focusing on identity work and legitimation in the narratives. Chapters Four and Five explore the work narratives of certified nurse-midwives and direct-entry midwives, respectively. The important questions here are: What kind of identity work are they engaged in as they talk about their work or about how they came to be involved in midwifery? What legitimizing discourses do they utilize as they tell their stories? Are there differences between LMs, CNMs, and empirically trained midwives? Chapter Six looks at the historical tension between midwifery and medicine and demonstrates how current tensions are negotiated in the narratives of these midwives. Specifically, I outline the ways that midwives use a discourse of medical collaboration in constructing their everyday work. In the last of these substantive chapters, Chapter Seven delves into the identity work of midwives in relation to the public. Some of the questions I pose are: What is the public perception of midwifery and should it be changed? If so, how? In their responses, midwives work to construct a public self and a collective public face for midwifery.

Chapter Eight revisits the debates in narrative analysis and discourse theory, raising questions of narrative and identity. I also outline future projects using data from this dissertation research. Finally, I describe why this work is important for the midwifery community.

CHAPTER 2
THE RESPONDENTS AND METHOD OF PROCEDURE

This chapter begins with a description of how I obtained my respondents. It moves into a characterization of the respondents themselves and a sketch of several of the sites at which I was a participant observer. Following that, I describe the interviews and the process of analysis. I end this chapter by discussing two important potential problems I encountered in the field.

The Respondents

This study is based on in-depth, open-ended interviews with 26 direct-entry and nurse-midwives at various stages in their careers. The interview participants are students, practitioners, and retired midwives. I had originally planned to do a participant observation study at a particular site within the midwifery community. In May 1999, I began to volunteer at the site. About a month and a half into the field work, I was informed by a gatekeeper of the organization that I would not be allowed to use any participant observation data from this site in my research. At first I was very discouraged, but I began to reconceptualize the project and decided to use interviews to obtain the work narratives of midwives. I continued to volunteer at the site, in part because I enjoyed it, but more importantly to make sure that my interviews and my writing would be ethnographically informed.

Through this volunteer position, I became active in the midwifery community, participating in workshops, meetings, and various events. In the process I met many potential respondents. After a few months of volunteering and being involved in the midwifery community, I began to recruit respondents. The goal was to interview both nurse-midwives and direct-entry midwives at various stages in their practice. The broad categories I used were student midwives, practicing midwives, and retired midwives.

The first several interviews were with people who I met at workshops and asked if they would be interested in participating. Applying the method of "snowball sampling," each of these people gave me names and phone numbers of other midwives, who I then contacted and asked to participate. Within this community, I had access to each category of midwife, except student nurse-midwives. To reach this group, I contacted the director of a nurse-midwifery program in the state, who helped me contact students.

Two groups of midwives that I had hoped to include in the study were lesbian midwives and underground midwives, or those practicing illegally. Although the women I interviewed often alluded to midwives in both categories, I was not able to obtain names until after I had completed data collection. While I hesitate to speak of these two groups in the same context, not wanting to "closet" lesbians by grouping them with illegal, underground midwives, in a way it makes sense to speak of them together. A large portion of home birth clients are religious fundamentalists from a variety of denominations, who would object to a lesbian attending their birth. For this reason there seems to be some secrecy surrounding lesbian midwives. Even more secrecy surrounds

underground midwives, because practicing without a license constitutes a felony in the State of Florida.

Description of Respondents

In the final count, I interviewed two empirical midwives who, while no longer practicing, remain active and vital participants in the midwifery community. One respondent was trained empirically, although did not practice as a midwife, but as an assistant to a midwife. In an effort to maintain confidentiality, I refer to this midwifery assistant throughout as an empirical midwife, otherwise she might be too easily identified. I also interviewed five practicing LMs, four direct-entry student midwives, and three "retired" LMs. My respondents also include five practicing CNMs, two student nurse-midwives, and four "retired" CNMs. In each group (LMs and CNMs), the women who claimed to be retired, may no longer be "catching babies," a term midwives use to describe their work during birth, but all are still working in different areas of women's health, (including gynecology and well-woman care, and maternal and infant health nursing), teaching midwifery students, teaching childbirth education classes, and engaging in research. One retired respondent is currently in the process of writing her memoirs.

It is important to note that although it is individual midwives telling their stories, my analysis in this study does not focus on the individual. Who these women are and what they say cannot be understood separately from the legitimizing discourses of the profession. Conversely, it is also important to caution the reader not to think about these discourses as templates for identity work, but rather as guiding frameworks within which individual midwives craft their stories.

Data Collection

Data for this dissertation was obtained through participant observation, in-depth interviews, focus groups, and collecting written documents. Below I describe three field sites, the interview process and other methods of data collection.

Field Sites

Gubrium and Holstein (1999) describe the analytic tension between ethnography and narrative. They characterize ethnographic excess as ignoring dissenting voices and narrative excess as missing the patterned range of narrative possibilities that, in some ways, exert narrative control over storytelling. Because I am focusing on narrative, I heed their warning to consider the circumstances and conditions of storytelling that may not be evident in the individual narrative account. As the researcher, I must be careful to contextualize these accounts through ethnographic description and comparison.

Following this advice, I have been a participant in workshops, banquets, and social gatherings of midwives. I have attended childbirth education classes, have received preliminary certification training in labor support, served in a labor support role at a birth center birth, and been involved in an effort to start a labor support cooperative. After being involved in these various activities for about one year, I was asked to serve in an administrative position at one of the sites. Ironically, the position I took replaced the gatekeeper who initially denied my access to participant observation data. These opportunities provide an ethnographic sense of the community.

Three of my primary field sites include what is called "doula" (labor support) training and a subsequent doula cooperative, a school for direct-entry midwifery, and a

birth center staffed by both LMs and CNMs. Many of my respondents either currently or in the past have served in the role of doula. Doulas are trained to provide emotional support, comfort measures, and advocacy for the laboring woman and her partner. They work as volunteers or paid support people in hospital, birth center, and home birth settings. This caregiving role has emerged as an occupation over the past decade (Morton 2000). The training in which I participated involved a two-day workshop in the summer of 1999 and a follow-up, daylong workshop in the summer of 2000. The second workshop was specifically geared toward providing labor support for women who are survivors of sexual abuse. Following the initial workshop, several women who attended attempted to initiate a doula cooperative. We had many meetings in which we learned from experienced doulas, watched video tapes of doulas at work, and discussed advertising and trying to gain entry into the hospital.

The school, in its current manifestation, began in 1995. It provides a three-year midwifery education curriculum that includes both academic and clinical training. The school also offers a midwifery assistant program, continuing education courses, and training that leads to provisional certification in childbirth education, lactation counseling, and labor support. Many of the original founders of the school are still involved as administrators and board of director members. I began as a volunteer at this school. After data collection was completed, I was asked to serve in a paid position as the academic director. I also taught research methods as part of a course titled "Issues in Professional Midwifery" to the senior students at the school.

One particular birth center was also integral to this study. It is owned by a CNM and her husband and staffed by the owner and a licensed midwife, along with direct-entry and nurse-midwifery students. They also have an obstetrician who signs their protocol and serves as a back-up physician. The birth center houses a library with books and videos on pregnancy, birth, and parenting. It also offers childbirth education classes, which I attended, and weekly gatherings for new parents and their children. Women go to the birth center for all of their prenatal care as well as during labor and delivery. There are two birthing rooms at the birth center. Both rooms are very "homey" with king size beds, rocking chairs, and soft lighting. One of the rooms also includes a large whirlpool tub. I had the privilege of attending a birth of a friend and colleague in the role of doula at this birth center.

In addition to participant observation and interview data, I also collected any written material I could find, such as promotional material, informational material, and the laws governing midwifery. I also surfed the websites of several midwifery organizations, including the Midwives Alliance of North America, American College of Nurse Midwives, and the consumer group, Citizens for Midwifery, among others.

The Interviews

I used a semi-structured interview guide (see appendix). Questions were adapted depending on whether respondents were students, practicing or retired midwives and whether they were nurse, licensed, or empirical midwives. Often, in the course of their narratives, respondents covered topics before I asked about them. Often, during the

interview, topics not listed in the interview guide were covered, and not every respondent was asked every question.

The interviews were usually conducted in participants' homes. Some were conducted in offices with various amounts of activity going on around us. Often the women I interviewed were "on-call" for a birth, but none of them ever had to leave in the middle of the interview, although in one case, a laboring woman called in the middle of the interview and was on her way to the birth center. The interviews lasted from one to three hours, were tape recorded, and later transcribed. In three instances, interviews were conducted via e-mail. I used e-mail as a last resort for participants who lived farther away than I was able to travel. The downside to an e-mail interview is that as the interviewer, I am unable to interactionally probe for further information or ask other questions that might arise as the interview unfolds. All of the e-mail participants, however, told me that it was okay to ask more questions or clarify points later via e-mail.

One problem that I have faced is the issue of confidentiality. The midwifery community in Florida is relatively small and "close-knit." All the participants in this study know one another, most have worked together in different capacities in the past and many currently work together. This creates a situation in which, despite my best efforts to maintain confidentiality, it is quite possible that when the midwives of Florida read the results of this study, they may be able to identify individual respondents. As a result, I chose to identify respondents by fictional names and to delete any potentially identifying information. I have consulted with several of the respondents regarding this admittedly imperfect approach and they agreed that it is the best strategy.

I have also encountered a few technical difficulties in interviewing and transcribing. In one instance, the quality of the tape recording turned out to be particularly poor, and on another occasion I did not notice that the first side of the tape had run out and I missed recording two entire questions. In the first instance, I transcribed all that I could of the interview and later e-mailed the respondent to fill in important gaps. In the second instance, immediately after the interview, I reconstructed from memory the answers to the two missing questions and then called the respondent to confirm what I had remembered. Also, on several occasions, after an interview concluded and I turned off the tape, the respondent and I continued to talk and I would ask if it was okay if I turned on the tape recorder again. In these cases again, I took notes immediately after the interview to reconstruct what we had talked about.

Active Interviewing

Atkinson and Silverman (1997) remind us that those of us living in western industrialized nations live in an "interview society," in which the self is established as an object of narration. Most adults, as part of this interview society are at least familiar with interviewing, whether through participation in surveys or by way of interviews with social service institutions, or as audience members observing media interviews. That we live in an interview society has important consequences for the way we approach social science interviews. Interviews cast respondents into the role of respondent with the expectation that they will talk about their experiences, or their opinions, or their lives. The point made here is that the interview is dependent on cooperative activity and a shared notion of the research process. In cultures that are not part of the "interview society," do not share the

familiarity of the process, or perhaps do not place a high priority on talking about themselves, very different data will inevitably emerge (Miller 1997; Bowler 1997; Alasuutari 1995).

My approach to interviewing is constructionist, as compared to a more traditional, positivist approach. The most fundamental and basic difference between a positivist approach and a constructionist approach is that while positivists view reality as existing independent of the knower, constructionists understand reality to be produced through talk and interaction. Silverman (1993) describes an ethnomethodological approach to interviewing in which he invokes Cicourel (1964), one of the first to point out that since interviews are social encounters in which interviewer and interviewee are engaged in social interaction, then they must be treated or analyzed in the same way as any other social encounter. That interviewer and interviewee play different roles, manage impressions, and negotiate meaning is not seen as problematic. Rather, this is seen as something that can be meaningfully analyzed. This ethnomethodological approach follows Garfinkel's (1967) project in which he took as his object of study "the activities whereby members produce and manage settings or organized everyday affairs [which] are identical with members' procedures for making those settings "account-able" (p. 1). So, through talk and interaction, the interviewer and interviewee are not only constructing reality, but a reality that is accountable.

Holstein and Gubrium (1995) present interviews as "active." They remind us that all interviews are interactional and thus are sites of knowledge production. This approach views the interview as a collaborative process between the interviewer and interviewee in

which the subject is interactionally constituted in relation to the developing context of the interview. The respondent in this case is seen as a competent narrator of experiential knowledge. Further, rather than a "neutral" interviewer, the active interviewer encourages narrative production by offering resources and points of reference for the interviewee. This is vastly different from a positivist model in which an active interviewer would be reprimanded for contaminating the data.

In the active interview approach, there is a recognition of the multiple subject positions from which both the interviewer and the interviewee can speak. For the interviewer, one subject position might be concerned with the substantive or the "what" questions of the interview and the other subject position might be concerned with "how" reality is being constructed. The interviewee may take on many different roles throughout the interview, speaking, say, as a woman, as a mother, or as a teacher. Because of the collaborative process of interviewing, the interviewer can also cast the interviewee into various roles, asking for example, "how might you think of this differently as a mother than as a teacher?"

While a positivist approach to interviewing considers the respondent a passive vessel of answers, a constructionist approach views the interviewee as possessing "stocks of knowledge" (Schultz 1967) that shift in relation to the role he or she is assuming at any given time. Using these stocks of knowledge, the interviewee draws on different resources to make sense of her experience. Highly structured, pre-coded interview formats, as used in the positivist approach, suppresses the meaningful linkages that could be made in reference to a particular question. For example, a midwife might be

dissatisfied with her job because of ungrateful students or because she spends too much time away from her family. When speaking as a teacher, she might link the meaning of job dissatisfaction to the students and when speaking as a mother, she might link the meaning to missing her children. The narratives that are produced through active interviewing allow "horizons of meaning," or meaningful and patterned "narrative linkages" to emerge (Holstein and Gubrium 1995). Whereas a positivist model is concerned with random or representative samples of a particular population of bodies, the active interview approach borrows from grounded theory the concept of active sampling, an ongoing process of soliciting and analyzing representative horizons of meaning (Glaser and Strauss 1967).

I began each interview by asking respondents to tell me the story of how they came to be involved with midwifery. In many cases, this question led to a long narrative incorporating their training and their practice of midwifery. If respondents did not address these issues on their own, I asked them to talk about their training and practice. I also asked respondents to tell me about the relationship they have had with the medical community and whether this relationship has changed over time. Finally, I asked them to describe what they believe to be the general public's perception or understanding of midwifery. Many other questions came up over the course of the interviews, but these are the ones that are directly addressed in this project.

Further, in addition to the one-on-one interviews and the participant observation, I was invited to observe two focus groups conducted by another researcher. These groups included many of the same women who later participated in my interviews. One group was made up of five, first-year direct-entry midwifery students. The second group

consisted of 10 practicing and retired direct-entry and nurse-midwives. I do not have access to the transcriptions of these focus group interviews, but I was permitted to take notes and consider these notes to be a source of data which provides a comparison of how these women might tell a different or a similar story in a context other than that of the one-on-one interview.

Analysis

In this study, as with most qualitative research, data collection and analysis took place simultaneously. As a framework for the project began to take shape, I carefully selected respondents who would provide data that could elaborate the framework. For example, I began the project looking for respondents in the broad categories of student, practicing, and retired direct-entry and nurse-midwives. But, as key concepts emerged and a working theoretical framework developed, I realized that I needed to be sure to interview nurse-midwives who follow more closely to a medical model as well as ones who do not. I also realized that I must interview women who practiced as unlicenced direct-entry midwives as well as those who have practiced or are practicing under the current laws. This approach is similar to that of the theoretical sampling of grounded theory (Glaser and Strauss 1967; Glaser 1978; Charmaz 1983).

In the process of analysis, I had to make a choice. Would I compare different types of midwives or would my analytic focus be theme-based? I choose to analyze responses based on themes because there is much overlap in the stories that different types of midwives tell. When appropriate in the substantive chapters, I point out differences

between LMs, CNMs, and empirical midwives or differences between student, practicing, and retired midwives.

Role Conflicts in the Field

Like many researchers before me (for example Loseke 1992; Thorne 1978), during the field work and interviewing for this project, I faced two distinct role conflicts. These involved identities or *selves* that I both brought to the field and created in the field (Reinharz 1997). My role as a researcher came into conflict at times with my role as an administrator and at other times with my role as a potential consumer. I took the administrative position after all of my interviews were completed and after I had stopped actively collecting participant observation data. Thus, this conflict did not affect the data collection process, but it does bring up issues of the relationship between researcher and participants. My role as a potential consumer did influence the data collection process. Below, I describe its influence and the steps I took to address this potential problem.

Conflicting Roles: Administrator and Researcher

With my new administrative status, I was suddenly placed in a position of authority over people that I had initially met in the role of researcher. As a feminist researcher, I had worked hard to establish trust and rapport with the participants and to minimize the hierarchical dimension of our relationship (Acker, Barry, and Esseveld 1983; Reinharz 1992; Wolf 1996). I did not sense discomfort on the part of the participants interacting with me in this new role, but I was extremely uncomfortable. I made an effort to let each person know that any information obtained in the context of this new relationship would

not be used as research data. Because I began the administrative job after the completion of active data collection, this has been an easy promise to keep.

Conflicting Roles: Researcher as Potential Consumer

A conflict that I believe had more of an influence on the data collection process and one that I had to attend to in the writing/representation process is that of my role as potential consumer. Because I have never seriously considered having children, I have never, as a consumer, researched the different types of birth settings (home, hospital, birth center, water birth, etc.). For this reason, I am quite impressionable. I am impressionable on a personal level because, although I am not interested in having children any time soon, I might someday. I am easily influenced by the stories that the midwives tell, and different types of midwives tell different stories. Specifically, nurse-midwives tell different stories about birth and their role in it than do direct-entry midwives.

While all the midwives I have talked to uphold the ideal of choice in childbirth and view their role as empowering women to trust their bodies, the specifics of their idealism and perception of their own role in birth takes different forms. Each group constructs the other group in a way that establishes the boundaries between the two different types of midwives. The direct-entry midwives that I have spoken with talked about birth as a spiritual and life-changing experience for the birthing woman in which they, as midwives, play a large role. They tend to refer to the work they do as a "calling" or a "labor of love."

The nurse-midwives tell a slightly different story. Their stories also consider birth a special, even "holy," experience, but downplays, or makes more practical, the role of the

midwife. In one interview, a nurse-midwife suggests that her role in the actual birth experience is minimal:

> Well, I think as a beginning midwife I used to be really disappointed when it didn't work out the way it should have and I used to feel like a personal failure with it, for a lot of things of course that were beyond my control, but I think I, as I grew in my own life, you know I don't control other people's births, they have their own, their own story, their own script, and you know their own life with what happens to them and I just try to help safeguard birth. (Melanie, CNM)

Another nurse-midwife goes even further, claiming,

> but most CNMs think that LMs are way too idealistic, *they* think they are changing someone's life, but that doesn't happen - maybe one in a couple hundred - otherwise they just forget about you a couple weeks after the birth. (Casey, CNM)

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The direct-entry midwives that I have interviewed construct nurse-midwives in a distinct way. In particular, one direct-entry midwife's response when asked why she chose one form of midwifery over another, included a criticism of nurse-midwifery training,

> Because, you know, nurse-midwifery training is *fear* based. I've seen all these great nurse midwives, who've had home birth themselves, and they totally practice out of fear and they're just so quick to transfer and so quick to not just trust the process. (Nadine, LM)

For this respondent, fear can keep a person from being a good midwife. Earlier in the interview she commented that, "Yeah, I feel pretty comfortable. Ya know, if you, if you live in fear as a midwife, you can't be a really good midwife . . . you really have to trust the process." This direct-entry midwife constructs the "other" type of midwife as fearful and thus unlike her because she trusts the process.

Nurse-midwives also construct direct entry midwives as "other." One former nurse-midwife explains the uneasiness of many nurse-midwives with sharing a label with "other" midwives as follows,

> I don't know what's happening in the college of midwives [American College of Nurse Midwives], it's a little unnerving, do you want to change the name of the college from the American College of Nurse Midwifery to the American College of Midwives, and it was voted down. They wanted to stay nurse-midwives because they had started to embrace the "other" types of lay midwives into the fold. (Patty CNM)

The Personal Side of the Research

Field researchers have written extensively about empathy with respondents (Ellingson 1998; Ellis et al. 1997; DeVault 1990) and the transformative experience of fieldwork (Foltz and Griffin 1996; Reinharz 1992). I do not necessarily empathize with these women; I have only attended one birth and so cannot really *know* what their day-to-day work feels like. My political views are in-line with some of theirs in a very general way, but in terms of the actual work they do, I am an outsider. I also do not think I've been transformed. If I ever choose to have children, I might use a midwife, but chances are I might have made this decision even if I had not been involved in this research project. I simply had never thought about these things in a personal way before.

This project has brought up thoughts and feelings that I did not expect to deal with on a personal level for many more years. Now, depending on which group (direct-entry or nurse-midwives) I listen to, my own idea of an ideal birth changes. I romanticize one over the other at times. And I have certainly romanticized the practice of midwifery over the practice of obstetrics.

How does my fluctuating view of birth and the profession of midwifery influence the types of interview questions I ask? Do I become skeptical of one group over the other and does this skepticism surface in my interactions with them? As an interviewer I am involved in the construction of the story that the respondents tell about their work and thus must be conscious of and attentive to these questions. I do not see this dilemma as a problem of contaminating the "results." But I do see my potential skepticism as hindering the rapport I form with respondents. Again, I do not consider rapport important in the sense that good rapport will elicit better and truer stories, but rather richer stories and richer data.

Clearly, I am by no means the first researcher to deal with these questions. Yet, no one seems to offer hard and fast solutions. Perhaps that is not the nature of interpretive sociology. One way that I have decided to deal with these issues is to use my skepticism as part of the interview process. For example, I might say to a direct-entry midwife, "some of the nurse-midwives I have talked with seem to think that direct-entry midwives as a whole are a bit too idealistic. What do you think about that?" To a nurse-midwife I might say, "some direct-entry midwives that I have spoken with suggest that nurse-midwives as a whole, being trained more closely to a medical model, do not trust the birth process. What do you think about that?"

This type of questioning places me unabashedly in the position of collaborator (Holstein and Gubrium 1995) in the construction of the "other" midwife. The "other" midwife then becomes a resource for me, the interviewer, as well as a further interpretive resource for the respondents to use in making sense of who they are and who they are not.

CHAPTER 3
LEGITIMIZING DISCOURSES

There are many legitimizing discourses that midwives in Florida make use of in telling their stories. There are historical, political, legal, regulatory, social and comparative cultural discourses that currently inform midwifery practice, as well as broader cultural discourses such as education, professionalization, science, nature, spirituality, feminism, and medicine, especially alternative medicine. Because my primary data are narrative accounts, my analysis does not focus on what midwives do, but rather on how they talk about what they do. The leading question of this chapter is what discourses are available for midwives to use to construct their identities and to legitimize their work?

Historical Environment

Much has been written about the history of childbirth in the United States (see Arms 1994; Chase and Rogers 2001; Leavitt 1986; Litoff 1978; Mitford 1992; Rothman 1991(1982); Sullivan and Weitz 1988; Wertz and Wertz 1989(1977)). Also, the history and development of both nurse-midwifery and direct-entry midwifery has been carefully and comprehensively documented by Judith Pence Rooks in *Midwifery and Childbirth in America* (1997). In this section, I outline broadly the history of childbirth and midwifery in the United States in order to give the reader a general sense of the historical context that has preceded the environment in which midwives currently practice. All of the

midwives in this study have some level of understanding of the history of midwifery. This knowledge has been acquired by some through their midwifery education programs. Other women, whose training took place under different requirements, have taken it upon themselves to be well-read on the history of their profession. Because the midwives I interviewed have knowledge of this history, it can serve as a sense-making resource in their stories. Not only is this history available as a resource, it also makes up a piece of the framework from which midwives' work narratives can unfold.

Midwives have attended women in birth throughout time. Historically, most midwives learned their skills by observing more experienced midwives. The first documented midwifery training program was in Athens, Greece in the 5th century B.C. and was started by Hippocrates (Roush 1979). Midwives continued to practice with different levels of training and regulation through the years, at times regulated by the state and at other times regulated by the church. Because of their healing skills and knowledge of herbs for healing and abortion, many midwives were the targets of witch hunts between 1450 and the mid-1700s. Estimates of the number of people executed as witches during this period range from 60,000 to several million, with 80 percent of those being women (Barstow 1992; Ehrenreich and English 1973; Nelson 1979; Scheuermann 1995).

Midwifery and the Rise of Medicine

In Europe, during medieval times, midwives attended women in birth. Men were called upon at times to perform surgery and save either the life of the mother or the child. In 17th century England, barber-surgeons, in order to save the mother's life, sometimes extracted impacted fetuses with various tools such as sharp hooks. The only way to make

these extractions was to crush the skull of the fetus. These tools were not designed to extract a live fetus, until Peter Chamberlen invented the forceps in the early 1600s. This invention allowed the doctor to extract a fetus without killing it. While Chamberlen and his family kept this new invention a secret for many years, by the 18th century the forceps were widely known to English doctors. With these new tools available, medical men had a technological advantage over midwives. This initiated the medicalization of childbirth (Rothman 1991(1982); Wertz and Wertz 1989(1977)).

Midwives came to the United States as colonists and later as immigrants and slaves. They brought with them varying degrees of education, skill, and knowledge about birth. English colonists brought with them to the New World customs and practices surrounding childbirth. Particularly, birth was a social event attended by several women in the community who also aided the new mother during the weeks after birth, called the "lying-in" period (Wertz and Wertz 1989(1977)). Women who came to the new world as slaves were what we now refer to as "granny midwives." They became midwives in response to the needs of the plantation and assisted in the births of both the black and the white women of the plantation. After emancipation, these midwives continued to serve the needs of their communities, particularly in the South. Because the women they cared for often had little access to healthcare, granny midwives attended complicated births as well as normal deliveries (Fraser 1995; Rooks 1997).

In the United States, from 1750 to 1810, midwifery was shared between men and women. There were both midwives and "man midwives." In 1828 the term "obstetrician," derived from the Latin, meaning "to stand before," came to replace man midwife. In the

years after 1810, men began to return from European medical schools. Doctors endorsed more extensive interventions in birth, leading to the view that a certain degree of mastery was needed. Importantly, women were seen as being unable to achieve this degree of mastery. While midwives in the 19th century United States never organized, this was not true of the medical profession. They developed professional organizations and leadership. Organized as a cohesive political group, the male dominated medical establishment proceeded to take control of childbirth (Leavitt 1986).

The American Medical Association (AMA) was founded in 1848, but was not successful in enforcing standards until the end of the century. Even with the establishment of the AMA, medical training was typically substandard and 90 percent of practicing doctors had not even attended medical school as documented in the Flexner report of 1910 (Flexner 1910). This report led to state regulation of medical schools. Because women were often denied admission to medical schools, special colleges for women were started. The first of these, the New England Female Medical College, was founded in 1848. Several of these colleges developed in the next 20 years, but only one, Women's Medical College of Philadelphia, survived the increased standards put into place after the Flexner report. Further, because women were frequently denied access to clinical training in many hospitals, they began opening their own. These hospitals often served poor women, as midwives saw medicine as a public service rather than a scientific endeavor.

Campaign Against Midwives

In the late 19th century, physicians began a campaign to eliminate the practice of midwifery, especially in areas where doctors were readily available to provide obstetric

services. As part of this campaign, midwives were blamed for the high maternal mortality rate in the United States. Most of the deaths were caused by puerperal fever, a postpartum infection of the uterus and other organs. Although far more cases of puerperal fever occurred in hospitals, under the care of a physician, midwives were not in a political position to counter these accusations. Largely comprised of immigrant, black, and poor women, midwives did not have the resources to influence institutions or to counter the widespread prejudices against women and racial and ethnic minorities. With the midwifery debate in full swing from about 1910 to 1935, midwives were deemed incompetent and untrained. On another level, physicians were attempting to promote pregnancy and birth as dangerous and complicated events that must be cared for by trained specialists. They accused midwives of undermining the progress of medical obstetrics.

Two basic and conflicting solutions to the "midwife problem" were proposed. Private physicians and academic obstetricians wanted to bring midwifery under the control of doctors and to have the elimination of midwifery practice as an ultimate goal. The medical establishment used a dual strategy of boundary definition between medicine and midwifery. Some were engaged in an inclusionary strategy of de-skilling the occupation of midwifery by creating a division of labor in which medical men attended to abnormal or complicated births and midwives, under the strict guidance and supervision of the medical profession, attended to normal births. Others were interested in excluding midwives altogether by bringing childbirth and everything associated with it into the exclusive domain and control of the medical profession, thus effectively eliminating the profession of midwifery (Witz 1992).

A second solution to the "midwifery problem" was posed by public health leaders, especially in the South, who thought that it would be more beneficial to train and educate midwives since it would be impossible for doctors to provide medical care to all women. Southern midwives were providing services for poor, working class, rural, immigrant, and black women, not the well paying clientele sought out by physicians (Rooks 1997; Sullivan and Weitz 1988).

The public health supporters of midwifery education celebrated a small victory in 1921 with the passage of the Sheppard-Towner Maternity and Infancy Protection Act, which provided funds for states to develop maternal and infant health services. Fourteen states used the funds to provide midwifery training and regulatory programs. However, by 1929 the Sheppard-Towner funds were no longer available, and by 1935, midwives were only attending 12.5 percent of births nationwide. Further, by this time, 80 percent of all midwives were located in the rural south. The campaign to eliminate midwives had effectively worked (Sullivan and Weitz 1988).

The Development of Nurse-Midwifery

The first midwifery training program, established through public funding, began at Bellevue Hospital in New York in 1911. Advocates of midwifery training introduced the idea of the "nurse-midwife" as an alternative to the traditional midwife. In 1925, Mary Brekenridge brought nurse-midwives from England to the United States and established the Frontier Nursing Service (FNS) in rural Kentucky. The nurse-midwives traveled by horse-back to provide midwifery and nursing services to the surrounding areas. Through excellent record keeping, FNS was able to document its success. Maternal and infant

mortality rates in the rural counties served had been among the highest in the country before their arrival. The services of FNS led to a dramatic drop in mortality rates Rothman 1991(1982); Rooks 1997; Wertz and Wertz 1989(1977)).

By 1945, five nurse-midwifery schools had been established in the United States: Frontier Nursing Service in Kentucky, The Lobenstine Maternity Center Association in New York City, The Tuskegee School of Nurse-Midwifery in Alabama, the Flint-Goodridge School of Nurse-Midwifery in New Orleans, and the Catholic Maternity Institute School of Nurse-Midwifery in Santa Fe, New Mexico. The schools in Alabama and New Orleans were attended by black public health nurses and closed soon after their initiation. The New Orleans school closed in 1943, and the Alabama school closed in 1946. All of the schools were designed to train midwives who would meet the needs of medically underserved populations. The graduates of these programs worked in rural areas or urban slums, serving poor families. It was not until 1955 that the first mainstream medical institution, the Columbia-Presbyterian-Sloan Hospital in New York City, accepted nurse-midwives (Rooks 1997).

Hospital Practices and Consumer Movements

In the early part of the 20th century, an increasing number of births were taking place in hospitals. Because of this shift, certain practices, particular to medicine, came to be regarded as routine. Twilight Sleep, a mixture of morphine for pain relief and scopolamine which served as an amnesiac, was adapted for obstetric use by an Austrian physician (Caton 1999). Women from the U.S. who could afford to travel to Europe were praising this new miracle that eased the pain of childbirth, and began a campaign to bring

Twilight Sleep to the United States. In 1915, with the help of Dr. Eliza Taylor, the Twilight Sleep Maternity Hospital was opened in Boston. Throughout the 1930s and 1940s, Twilight Sleep was used routinely in hospitals (Leavitt 1980; Wertz and Wertz 1989(1977)). In addition to advocating this practice, Dr. Joseph DeLee (1940) taught that women should be in the lithomy position (lying on their backs) during labor, should be sedated from the first stages of labor, should receive an episiotomy (a cut from the vagina to the anus), and that physicians should use forceps to speed up delivery. He recommended the routine use of these practices, and his teachings became standardized in obstetrical practices well into the 1960s.

In the 1940s and 1950s a small natural childbirth movement began in the United States. Grantly Dick-Read, an English obstetrician, wrote *Childbirth Without Fear: The Principles and Practices of Natural Childbirth* (1959), which was first published in the United States in 1944. He proposed that much of the pain of labor was a result of tension and fear and argued that women who understood birth as a normal process and had confidence in their own ability to give birth could do so without fear, and thus with less pain. Dick-Read's ideas led to the establishment of childbirth education classes and new techniques of breathing to reduce pain. This method influenced Robert Bradley, who developed husband-coached childbirth in which the partner of the pregnant woman became her breathing coach. Yet another type of breathing technique to control pain during contractions was developed by Ferdinand Lamaze in the 1950s.

By 1960, 97 percent of births in the US were hospital births (Rooks 1997). The experiences of women in the hospital were not ideal. In November 1957, a letter appeared

in *Ladies Home Journal* (*LHJ*) that set off a flood of responses relating to women's experiences of disappointing, shocking, and even torturous hospital practices. The original letter was written by a registered nurse,

> I have seen doctors who have charming examination-room manners show traces of sadism in the delivery room. One I know does cutting and suturing without anesthetic. He has nurses use a mask to stifle the patient's outcry. Great strides have been made in maternal care, but some doctors still say, "Tie them down so they won't give us any trouble." (Cited in Mitford 1992:60-61)

The responses were printed in the May 1958 issue of *LHJ*. One woman, a mother of three, wrote,

> The practice of obstetrics is the most modern and medieval, the kindest to mothers and the cruelest. I know of many instances of cruelty, stupidity and harm done to mothers by obstetricians who are callous or completely indifferent . . . Women are herded like sheep through an obstetrical assembly line, are drugged and strapped on tables while their babies are forceps-delivered. Obstetricians today are businessmen who run baby factories. (cited in Mitford 1992:61)

Increasing consumer criticism of the medical management of childbirth and the emergence of an alternative birth movement in the 1960s and 1970s coincided with the civil rights movement, the women's movement, various other consumer movements, the antiwar movement, and the health food movement (Daviss 2001; Mathews and Zadak 1991; Umansky 1996). Importantly, it also coincided with the introduction of the birth control pill in 1960. Because women were having fewer children, particularly women in the middle-class, they were searching for a more rich and emotionally satisfying birth experience. As consumers, these middle-class women began to seek out midwives. This

led to an important shift for a group who had previously served primarily poor and rural women.

In the early 1970s, some women took their criticism of medical management a step further and refused to birth in a hospital. They decided to birth at home by themselves. With other, like-minded women they began to study and learn about birth. They read medical texts, but also relied on "birth stories" as evidence of their authoritative knowledge surrounding birth. Birth stories are narratives of experience and birth outcomes that are shared with the community (Lay 2000). This coincided with the publication of several texts, critical of the medical establishment and advocating that women take control of their bodies (i.e. *Our Bodies Our Selves*; *Immaculate Deception*; *The Birth Book*; *Spiritual Midwifery*). On the west coast, Raven Lang started the Santa Cruz Birth Center which provided prenatal and postnatal education for women planning home births. On the east coast, Ina May Gaskin initiated the midwifery practice on The Farm, a collective in Summertown, Tennessee. The lay midwives in each of these locations kept excellent records of their birth outcomes and were able to show that for normal, low-risk pregnancy, home birth was as safe as hospital birth.

During this period, midwives around the country were practicing illegally in an underground network and often feared legal action or the threat of it. The Santa Cruz midwives were the target of a sting operation in the early 1970s. The State Board of Consumer Affairs sent a pregnant undercover agent to the birth center along with a confederate "husband." The midwives responded to this woman's call when she pretended to be in labor. When they arrived at her house, they were arrested for

practicing medicine without a license (Rooks 1997; Ventre et al. 1995). In the late 1970s several women in Florida were also under legal scrutiny. There were cases pending in Stewart, Tampa, Clearwater and Jacksonville. A woman with a large underground midwifery practice in Jacksonville had been charged with practicing medicine without a license. The women in all of these locations worked collaboratively and eventually, through a series of highly publicized court cases, were successful in changing Florida's midwifery laws.

Political and Legal Environment

National Politics

The first professional organization for nurse-midwives was the Kentucky State Association of Midwives in 1929, which later changed its name to the American Association of Nurse-Midwives. In the late 1940s, nurse-midwives were part of the National Organization for Public Health Nurses and later, in the 1950s, were part of both the National League of Nursing and the American Nurses' Association. Dissatisfied with their lack of visibility in these organizations, a group of 20 nurse-midwives formed the American College of Nurse Midwifery in 1955, and later merged with the American Association of Nurse Midwives to form The American College of Nurse Midwives (ACNM). The goals of the organization were to establish standards for education, to sponsor research, to develop services, and to participate in the International Confederation of Midwives (Rooks 1997).

The ACNM has achieved much success as a political body. They have been effective in establishing training programs, in securing insurance and Medicaid

reimbursements for nurse-midwives, in gaining hospital privileges for CNMs, and in obtaining prescriptive authority for CNMs in many states. ACNM is currently active in the debates surrounding the expansion of CNMs' scope of practice to include primary care provision and in debating whether or not CNMs should be allowed to perform abortions.

In 1981, the ACNM's national convention included discussion as to whether they should expand membership to include direct-entry midwives. ACNM and the American College of Obstetricians and Gynecologists (ACOG) were looking for ways to communicate with direct-entry midwives, but there was no national organization that represented this group. The president of ACNM at the time, Sister Angela Murdaugh, convened a group of direct-entry midwives from around the country. This meeting led to the formation of the Midwives Alliance of North America (MANA) in 1982. The goals of MANA are:

> 1) To expand communication and support among North American midwives
> 2) To form an identifiable and cohesive organization representing the profession of midwifery on a regional, national, and international basis
> 3) To promote guidelines for the education of midwives and to assist in the development of midwifery education programs
> 4) To promote research in the field of midwifery as a quality health care option
> 5) To promote and support a woman's right to choose her care provider and place of birth
> 6) To promote public education and midwifery advocacy (Midwives Alliance of North America 1999a)

The Midwives Alliance of North America (1999b) currently is working toward several political goals. They seek access to affordable, community based midwifery care for all women. Although they acknowledge all midwives, MANA supports the

development of examinations and certification processes. Barring certification, they encourage midwives to use informed consent with their clients. Another goal of MANA is to decriminalize midwifery practice in places where it has been criminalized. Finally, MANA continues to seek insurance and Medicaid reimbursement for direct-entry midwives in states that have not already obtained this.

Legal Status of Nurse-Midwifery

Nurse-midwives practice legally in every state in the United States. However, the laws that govern their practice vary considerably. Educational requirements, the credentialing process, the scope of practice, authority to prescribe medicine, and the extent of required collaboration with physicians are key elements of these various laws. In Florida, nurse-midwives are licensed as Advanced Registered Nurse Practitioners. They are governed by the Department of Health, Board of Nursing, and practice under the Nurse Practice Act (Chapter 464, F.S.). Since 1988, Florida's nurse-midwives have had the authority to write prescriptions. They practice under a joint practice protocol, signed by both the nurse-midwife and a physician. In Florida, state law requires insurance companies to reimburse for nurse-midwifery services, and Medicaid must reimburse nurse-midwives at 80 percent of the physician rate (ACNM 2000).

Legal Status of Direct-Entry Midwifery

The legal status of direct-entry midwifery varies by state. It is illegal in eight states and Washington, DC.[1] In seven states, it is legal by statute, but licensure is unavailable.[2]

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[1] Washington DC, Indiana, Iowa, Kentucky, Maryland, Missouri, North Carolina, Virginia, Wyoming.

[2] Alabama, Delaware, Georgia, Hawaii, New Jersey, New York, Rhode Island.

Direct-entry midwifery is not clearly legal or illegal in seven states.[3] In 13 states, it is legal but not regulated.[4] And in 13 states, including Florida, it is legal and regulated through either licensure, certification, registration, or documentation[5] (Rooks 1997; Midwives Alliance of North America 1999d). Because midwives in many states are pushing for legislation to legitimate their work, and states where direct-entry midwifery is legal and regulated are often threatened with deregulation, the above categories shift and change.

Florida's midwifery law was in flux throughout the 1980s. A law passed in 1982 recognized the right of parents to choose the manner, cost, and setting for their child's birth. A Lay Midwifery Advisory Committee was established within the Department of Health and Rehabilitative Services (DHRS). Under this law, DHRS licensed midwives based on examination. To be eligible, one must be a high school graduate, in good health, and have completed an approved midwifery education program. An approved midwifery education program at the time was required to be associated with a state-accredited educational institution and provide three years of course work and clinical training. In 1984, two schools that met these requirements opened in Florida. However, in that same year, the 1982 law was reviewed and amended to limit licensing of midwives to those already enrolled in school. In 1990, Florida was suffering a crisis in maternity care and infant mortality. More people were using CNMs, but there were not enough CNMs to

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[3] Connecticut, Nebraska, Ohio, South Dakota, Vermont, West Virginia, Wisconsin.

[4] Idaho, Illinois, Kansas, Maine, Massachusetts, Michigan, Mississippi, Nevada, North Dakota, Oklahoma, Pennsylvania, Tennessee, Utah.

[5] Alaska, Arizona, Arkansas, California, Colorado, Florida, Louisiana, Minnesota, Montana, New Hampshire, New Mexico, Oregon, South Carolina, Texas, Washington.

meet the demand. This led to a reinstatement of the 1982 law with increased standards for education. Under the leadership of Governor Lawton Chiles, the Midwifery Practice Act passed in 1992 (Chapter 467 F.S.; Rooks 1997).

Regulatory Environment

The regulatory environment includes the various governing boards of midwifery education, licensure, and accreditation. For nurse-midwifery these are fairly standard throughout the United States. Because the status of direct-entry midwifery differs from state to state, I will focus specifically on regulations in Florida.

Certified Nurse Midwives and Certified Midwives

The designation of certified nurse-midwife requires that one first be a registered nurse and then receive a graduate degree from a nurse-midwifery education program accredited by the ACNM's Division of Accreditation (DOA). Certified midwives (CM) must also graduate from an ACNM DOA accredited nurse-midwifery program, but do not have to have a nursing background; rather they are allowed to have a background in some other health related field. The ACNM Certification Council (ACC) oversees the certification of CNMs and CMs through a national certification examination. After passing this examination, CNMs and CMs are licensed in the state in which they practice.

Licensed Midwives and Certified Professional Midwife

In the state of Florida, direct-entry midwives can be licensed if they graduate from a three year program of academic and clinical education and pass the North American Registry of Midwives (NARM) national certification examination. This is the same exam that certifies midwives as certified professional midwives (CPM). CPM is a national

credential that was first implemented in 1994 to certify experienced direct-entry midwives. It expanded in 1996 to include entry-level midwives. In addition to licensure by examination, midwives in Florida can also receive licensure by endorsement through the Council of Licensed Midwifery. This path is taken by midwives who received their training in foreign institutions. Licensed midwives in Florida are governed by the Department of Health.

Direct-entry midwifery education programs, including continuing education, are accredited by the Midwifery Education Accreditation Council (MEAC), established in 1991. To be accredited, a program must do a self-evaluation study, be inspected by an outside examining committee, submit its curriculum for review, and repeat the process every three to five years. There are seven midwifery schools in Florida approved by the Council of Licensed Midwifery, and one accredited by MEAC. The two oldest schools are Miami Dade Community College which opened in 1994 and the Florida School of Traditional Midwifery (FSTM) which opened in 1995. FSTM recently received accreditation by MEAC. In Florida, midwifery education programs must meet core competencies established by MANA and the ACNM's DOA.

Social Environment

At a recent baby shower for a close friend, I was fascinated by a conversation that took place. My friend was one month away from having her first baby. The women who had attended the shower were white and middle to upper-middle class, some of whom had children 20 or more years ago, some of whom had recently given birth, and a handful who had never had children. One new mother asked the guest of honor, "So, when do you

plan to have your epidural?" The conversation that ensued involved new mothers praising the pain relief of the epidural. Even women who had never experienced childbirth chimed in, claiming that they wanted their epidural in the hospital parking lot. In this group of more than 20 women, only one, whose mother-in-law had given birth to several children at home with a midwife, spoke up half-heartedly against epidural, claiming that her husband would never let her have one. What fascinated me the most about this discussion was the *assumption* of medically induced pain relief. Notice that the original question was not *are* you planning to have an epidural, but *when* (at what point during labor) do you want your epidural.

This anecdote sets the stage for discussing the social/cultural environment surrounding midwifery. Images of hospital birth and medical intervention abound in movies, advertisements, and television shows. Images of natural, home birth are much more rare. In a popular birth book, *The Complete Idiot's Guide to Pregnancy and Childbirth* (Gliksman and DiGeronimo 1999), which has 306 pages of text, only a half of a page is devoted to describing the option of a nurse-midwife, and the option of a direct-entry midwife is not even mentioned.

The interventions provided by doctors in a hospital are time related (Rothman 1983; Simonds 1999). In a culture that places such a heavy emphasis on time management, these interventions make sense. A woman who has a business trip scheduled for a certain date can schedule her cesarean section to fit nicely within her work schedule. A respondent told me about a woman she taught in a childbirth education class who asked that her labor be induced so that she could give birth before her own birthday.

Recently, midwifery has received national attention. The Learning Channel's program, *A Birth Story,* often shows midwife-attended births. In an episode of the television show *Dharma and Greg,* a character had a hospital birth attended by a midwife. A handful of celebrities have recently had home birth, attended by a midwife. As public figures, their births were material for talk show hosts and entertainment magazines. Further attention came with the naming of the novel *Midwives* by Chris Bohjalian (1997) as an Oprah Winfrey book club selection. This year, 2001, the novel was made into a Lifetime movie, starring Sissy Spacek. This publicity has had mixed reactions from real-life midwives. While Bohjalian gives a sympathetic and complex portrayal of a direct-entry, home birth midwife, the crux of the story is the murder trial that ensues after the main character performs an emergency cesarean section on a mother who she believes is already dead.

Comparing Global Midwifery Practice

The midwives in this study frequently referred to midwifery practices and more general issues of healthcare in other countries. They typically compared the United States to Western Europe, with Western Europe being on the more favorable end of the comparison. At times they also referred to countries such as Jamaica and Mexico to suggest that midwives in these cultures are accorded more respect than midwives in the United States. While there is a high degree of variation in the roles of midwives in Europe, most countries have laws regulating midwives, publicly funded schools for midwives, and professional associations to represent midwives (Rooks 1997). These

respondents also often cited as positive Europe's subsidized health care systems and lower infant and maternal mortality rates in Europe and other parts of the world. [6]

Broader Cultural Discourses

Several broader cultural discourses are used by the midwives in this study. Rushing (1993) examines the use of scientific discourse and feminist discourse in claims about the safety of midwifery practice and the rights of women to choose how and where to birth. Each of these discourses emerge in the stories told to me by the midwives. In their stories, the midwives draw upon not only the discourses of science and feminism, but also of alternative medicine, education and professionalization, and nature and spirituality as legitimizing discourses and meaning-making devices.

Science and Medicine

What is considered science is often determined by who practices it (Ehrenreich and English 1979; Rosser 1989; Schiebinger 1993). Historically, midwifery has not been considered a science, yet the medical field of obstetrics has been considered such. In a letter from 1911, a leading obstetrician, Dr. Joseph DeLee, complained about midwives to his colleague, another leading obstetrician, Dr. J. Whitridge Williams. DeLee stated,

> If an uneducated woman of the lowest classes [a midwife] can practice obstetrics, is instructed by doctors and licensed by the State, it certainly must require little knowledge and skill - surely it cannot belong to the science and art of medicine. (cited in Devitt 1979:91)

[6] For an overview of midwifery in Europe, Canada, Australia, New Zealand, and Japan, see Rooks (1997). Chapter 13.

A dictionary definition of science states that science is

> 1) a branch of study concerned with observation and classification of facts and especially with the establishment of verifiable, general laws. 2) accumulated, systematized knowledge, especially as it relates to the physical world. (Merriam-Webster 1974:20)

While midwifery has perhaps historically not been interested in producing general laws, those who practice midwifery have always been involved in close observation and accumulating knowledge related to the physical world of birth. A midwife I interviewed problematizes the practice of science by claiming that physicians do not practice scientifically, but midwives do. She describes a situation in which obstetrician's reliance on and hypervaluation of technology makes them scientifically irresponsible:

> I mean, by their own obstetrical studies, published in obstetrical journals, obstetricians do not practice scientifically, we do. You know, we're the ones who don't do continuous, electronic fetal monitoring, who don't do routine episiotomies, who don't do routine IVs, even though *their* journal literature says over and over and over again that they will put you at higher risk for C-sections and you know bad babies and for bad outcomes for mothers, blah, blah, blah, they don't practice that way. (Sandra, LM)

Alternative Medicine

The midwives, particularly the licensed and empirical midwives, in this study frequently invoked a discourse of alternative medicine, including massage therapy, herbalism, and acupuncture, to give meaning to the work they do as midwives. While a western biomedical model and an eastern holisitc model often overlap to some degree in practice, theoretically they are oppositional models. A biomedical model focuses on disease rather than prevention, treats mind and body separately, and relies heavily on technology and invasive practices (Loustaunau and Sobo 1997; Payer 1996(1988); Todd

1999). A holistic model views the person as a whole being situated in a social environment. Medicine is generally preventative and minimally invasive, a physical and emotional balance is sought, and patients are seen as active participants in their own healing (Goldstein 1999; LaPointe 2000).

Feminism

There are several feminist discourses available that midwives can and do use to make sense of their work. They include a feminist evaluation of health care, a feminist critique of the medical model of birth, and a radical feminist analysis of reproduction.

In May 1969, a workshop entitled "Women and their Bodies" held at a women's liberation conference in New England sparked a heated discussion about the patronizing treatment many of the participants had received from male doctors. The events of this workshop eventually led to the formation of the Boston Women's Health Book Collective which published *Our Bodies, Ourselves* first in 1970, then later editions, with the most recent published in 1998. The book marked the beginning of a second wave of activism focusing on women's health. A broad based women's health movement beginning in the 1970s and continuing to the present day intersected with movements for better birth control, better birthing options, and abortion rights. One aspect of this movement involved the formation of autonomous women's health centers and clinics which sought to empower women to know their bodies. Another aspect has focused on bringing a feminist perspective to health education and policy. And a third aspect of a broadly constructed women's health movement has sought to increase the numbers of women represented in health professions (Clarke and Olesen 1999).

Part of the feminist critique of health care in general has been a criticism of the medicalization of childbirth. Barbara Katz Rothman (1991(1982)) and Robbie Davis-Floyd (1992) have been at the forefront of the critique of what Rothman calls a medical model of birth and Davis-Floyd refers to as a technocratic model. One of the most striking differences between the medical or technocratic model and a midwifery model of care is how the subject (woman) is constituted. In a medical model, pregnancy is seen as pathological and the woman is seen as a patient in need of care. Consequently it is the doctor who delivers the baby. This is quite different from a midwifery model in which pregnancy is seen as a normal condition and the woman is the doer, the giver of birth. In this model, the woman delivers the baby with the help of the attending midwife. In the medical model, the traditional position for the pregnant woman is lying down (lithomy). This position is used strictly for the convenience of doctor. For the woman, it is typically a painful position that works against gravity and restricts her efforts to push, prolonging delivery. The midwifery model suggests a sitting or squatting position, which takes advantage of gravity, allows for the relaxation of the pelvis and for the baby to spread the pelvic bones. This position is more convenient for the woman. Further, the medical model relies on technology and medical interventions during birth. A midwifery model sees these as useful in high risk cases, but an unnecessary part of normal birth. Armstrong and Feldman (1990) suggest that society's increasing dependence on technology has prevented many women from being able to view birth as a natural process, and from being able to think of themselves as naturally equipped to handle this process. They argue that

women willingly accept unnecessary and uncomfortable procedures with the hopes and expectations that technology will deliver a perfect baby.[7]

Radical feminist analyses of reproduction focus on men's control over women's bodies (Corea 1985; Martin 1987; O'Brien 1983; Raymond 1993). They describe the medicalization of childbirth as a plot by (male) physicians to transform pregnancy into a disease as opposed to a natural condition, and to take over the birth process that had traditionally been a female-centered event, attended by skilled (female) midwives. This, radical theorists tell us, is an attempt by physicians to expand their authority and control over women's bodies through increased medical surveillance and management which renders women and women's bodies as passive objects. Mary O'Brien, in *The Politics of Reproduction* (1983), posits that men are alienated from the natural reproductive process to which women are integrally linked. The claim is made that in gaining ever increasing control over women's bodies, men will appropriate the power associated with procreation and eventually eliminate any need for women.

Education and Professionalization

Midwives are divided over the issue of education. Is a college degree necessary? Must one first be a nurse? What are the advantages and disadvantages of self-study or an apprenticeship model? In addition to disagreement among individual midwives, there is an historical conflict between ACNM and MANA over the most appropriate educational route for midwives (Tritten and Southern 1998).

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[7] For a more moderate account of birth practices, focusing on individual women's immediate social context, see Fox and Worts (1999).

Davis-Floyd (1998a; 1998b) outlines and evaluates several different types of midwifery training. At one end of the spectrum are formal university programs, and at the other are apprenticeship and self-study. Middle range education programs include distance-learning, university affiliated programs, college-based direct-entry programs, and private midwifery schools. Most of these types of programs to some degree combine didactic learning and experiential learning (Benoit et al. 2001). ACNM has tended to insist on formal university training and has moved toward requiring a bachelor's degree and even a master's degree, although they have very recently taken the position that one's bachelor's degree does not necessarily have to be in nursing. An evaluation of the first direct-entry program accredited by the ACNM shows clearly that students without a nursing background achieve the same standards of academic excellence and clinical competency as students who are nurses (Fullerton et al. 2000). MANA, on the other hand, insists that a university degree is not necessary for becoming a midwife, and recognizes the value of apprenticeship and self-study as legitimate forms of learning.

The upside to standardized education in midwifery includes recognition, legitimacy, access to government funding, and the possibility of training larger numbers of midwives (Davis-Floyd 1998b; Myers-Ciecko 1999; Osborn & Esty 1998). A downside to mandated standardized education is that it serves as an important means of social control (DeVries 1996). For many traditional midwives and advocates of an apprenticeship model, there is also concern that standardized education is increasingly moving in the direction of the medical model and that it will lead to the diminishing of the autonomy and independence of midwifery practice.

Nature and Spirituality

Wider cultural discourses of both nature and spirituality are often used when midwives describe the work they do and when women describe their birth experience (Klassen 2001). Based on other studies (Chester 1998; Davis-Floyd and Davis 1997), I expected to include nature under an ecofeminist discourse (Carson 1962; Daly 1978; Griffin 1979; King 1981; Rose 1993). However, the midwives did not speak of nature as a feminist issue, so I include a discourse of nature separate from feminism. Here I give examples of the use of nature and spirituality by practicing midwives. Penny Amrstrong, a CNM practicing in Pennsylvania, primarily in the Amish community, is dismayed by the cultural separation of women from birth and from the earth:

> The experience that I had from working with the Amish showed me that the farther you get away from the earth, the farther you take birth away. I think that each layer, each hospital floor takes you farther ways from the earth, then you lose the connections to the rhythms and the cycles. You can't reproduce in a plastic environment . . . I don't know what is holding women back from using midwives except that I think there is a cultural imperative to separate women from birthing, to separate families. I think that there is a cultural imperative to separate us from the earth from which we get all of our powers and animal instincts. (Chester 1998:46&51)

Connecting midwifery to spirituality, Ina May Gaskin in *Spiritual Midwifery* (1977), which several of my respondents referred to as the midwives' bible, writes:

> Every birth is Holy. I think that a midwife must be religious, because the energy she is dealing with is Holy. She needs to know that other people's energy is sacred. . . By religious, I mean that compassion must be a way of life for her. Her religion has to come forth in her practice, in the way she makes her day-to-day, her moment-to-moment decisions. It cannot be just theory. Truly caring for people cannot be a part-time job. . . the midwife must keep herself in a state of grace. She has to take spiritual vows just the same as a yogi or a monk or a

> nun takes inner vows that deal with how they carry out every aspect of their life. A midwife must constantly put out effort to stay compassionate, open and clear in her vision, for love and compassion and spiritual vision are the most important tools of her trade. (Gaskin 1977:276-277)

There are some groups of midwives who call upon spirituality in a slightly different way, with God as the highest authority. Groups of Christian midwives claim that women should be "allowed to labor and deliver the way God intended" (Christian Midwife Home Birth Service of San Diego 2000) or that as midwives they "are ultimately responsible to God as our highest authority, that He is the healer and we are merely his instruments in demonstrating his love and compassion" (Christian Nurse Midwives Association 2000).

CHAPTER 4
CERTIFIED NURSE-MIDWIVES

When I began to conceptualize this project, I had to make an analytic choice. Initially, I thought I would examine the ways in which different types of midwives (LMs, CNMs, empirical or student, practicing, retired) engage in identity work. But, as data collection and analysis progressed, it became clear that there were more similarities than differences among the various types of midwives' narratives. Therefore, I have opted to use a theme-based analysis. However, when analyzing the paths taken by midwives into their profession, the narratives of nurse-midwives differ in a very patterned way from the narratives of licensed and empirical midwives. As a result, I concentrate in this chapter on the narratives of CNMs and leave the narratives of LMs and empirical midwives to the next.

I began each interview with the question, "Can you tell me the story of how you came to be a midwife?" Because certified nurse-midwives must first be nurses, the stories of these women tend to have a very different starting point than the stories of other types of midwives. In other words, CNMs typically (eight out of eleven) begin their stories with nursing school or practice. Other studies suggest that, increasingly, CNMs claim "midwife" as their primary professional identity (Davis-Floyd 1998a; Scroggin 1996). Davis-Floyd (1998a) exclaims that "'I am not a nurse, I am a midwife!' is a statement I have heard countless times in my interviews" (p. 83).

Unlike CNMs, licensed and empirical midwives (discussed in Chapter Five) evoke a variety of starting points, the most common being the birth of their own children. Others begin their stories in the context of childhood, medical backgrounds, including alternative medicine, legal battles, and counterculture. While the narratives have a distinct starting point, the stories midwives tell about the paths leading up to their practice are sometimes short and succinct and sometimes long and winding, interwoven with stories of childhood, families, and life experiences.

The stories these midwives tell are not always told as linear narratives, which is especially true of the direct-entry midwives we will hear in the next chapter. Really, each story deserves to be treated as a case study. By presenting data in a theme-based analysis as I have chosen to do, we miss much of the continuity of each woman's story. For this reason, I will do my best to contextualize each narrative excerpt.

In the next two chapters, we will see midwives engaged in biographical work, that is, constructing who and what they are as midwives in relation to their lives as a whole (Gubrium and Holstein 1995; Holstein and Gubrium 2000b; Gearing 1999; Marvasti 1998; Ronai and Cross 1998). Providing information relevant to the topic at hand, respondents select, interpret, reinterpret, and contextualize aspects of their biography to make sense of and give meaning to the work they have done, are doing, and will do in the future. Through the telling of their stories, midwives "shape, support, and strengthen professional identity" (van der Hulst et al. 2001:166).

Entering the Profession

Scholars of work and occupations have long been interested in how and why people choose to enter certain professions (Brewis and Linstead 2000; Chumbler and Ford 1998; Glenn 1981). It has been suggested that for women, career choices are influenced by the socioeconomic status of the family, mother's occupation, academic achievement, age, attitude toward marriage, and social and religious attitudes (Gagne and Poirier 1985). Gender differences in occupational choice are also thought to exist, with women, more than men, attributing importance to intrinsic, altruistic and social rewards (Marini et al. 1996; Mottaz 1986). In this study I am interested in the paths these women took to the occupation of midwifery as revealed in narrative understanding. In the following excerpts, we will hear their narratives of entry. What comes forth is a more complex picture than a mere listing of variable conditions would suggest.

Through the Door of Nursing

When asked to tell how they came to be midwives, eight out of eleven nurse-midwives begin their stories by identifying themselves as nurses. Beyond that point, they draw upon a variety of resources, including education, family, and prior hospital experiences to further describe their paths to the profession. Melanie, a CNM working in a birth center setting, begins her story at a point where she had "gotten out of nursing." Listen as she narrates her path to becoming a midwife:

> I had gotten out of nursing, I had worked in psych nursing and I had gotten out, and my husband and I were working at a bar and restaurant we'd helped some friends start. And I had two children at the time and the second birth had been, although no bad results for either of us, had been pretty much botched by hospital routine and I had a lot of

> lingering kinds of feelings about that, that I couldn't really place. And then the book *Immaculate Deception* came out and a friend gave it to me and it really just kind of gave me a focus of why I had felt upset with that birth and what I could do. That I could make it different for other women and that was basically when I knew I wanted to be a midwife. (Melanie, CNM)

While she establishes nursing as a framework for her story, she quickly shifts to a negative hospital birth experience and a subsequent book that helped to make sense of that experience. The book helps her make sense of her experience and thus serves to legitimate her experience. Further, the experience and book together legitimate her decision to become a midwife and "make it different for other women." Biographical particulars clearly mediate her story to construct the account as her own.

I then asked Melanie how she went from knowing she wanted to be a midwife to actually becoming one.

> Melanie: Well, I went back into nursing, I decided that since I was a nurse I was going to go the certified nurse-midwifery route. I definitely believed in education and I didn't want to just go apprentice with somebody.
> Lara: And that was the only other option at the time?
> Melanie: That was the only other option at the time, and also I needed to go to a master's program because there was one were I lived and I couldn't really easily move my family or leave them; I had young children. Because I had probably wanted to go to the Frontier School of Nursing, where you didn't need to have a degree, at that time. But I went back to school and started nursing again and went back to school to get my bachelor's degree and did it kind of part-time, weekends, evenings, that kind of thing for a few years, then applied to midwifery school. (Melanie, CNM)

Here, Melanie returns to her initial framing of the story by "going back into nursing." She invokes education to legitimate her decision. At the time, nurse-midwifery was the only

route that offered a formal education. After deciding to pursue a degree in nurse-midwifery, Melanie then references her family situation--"I couldn't really easily move my family or leave them"--to give further meaning to the particular path she chose.

Interestingly, Melanie is one of the few CNMs who cited family concerns in relation to her decision-making process. This is consistent with much literature on work and family that suggests that women take family into consideration when making career decisions (Bielby and Bielby 1992; Frame and Shehan 1994; Gerson 1987; Hardill et al. 1997; Sidel 1990). What is interesting is that so few others mentioned family in the context of how they came to be a midwife. A few women cited family as reasons for changing direction in their career. For example, it was difficult to be "on-call" while raising children. They also cited family in the context of where they see themselves in the future, possibly cutting back hours in order to stay home and raise a family.

For Andrea, a student nurse-midwife, nursing is also the starting point of her story. She cites collaborative efforts between nurses, medical students, and doctors, but she ultimately rejects a medical model of birth in favor of "the natural, compassionate art of nursing." She chooses midwifery training as consistent with the type of care she wants to provide:

> I decided to go back to school for midwifery after working as a labor and delivery nurse in a teaching hospital for about three years. I was 25 and was ready for a change of pace in nursing. I always knew throughout nursing school that I wanted to work in obstetrics, and while working at this teaching hospital, I realized I knew the same, if not more, than the resident doctors practicing there. Each July, the new first-year residents arrived and basically they really knew very little about labor and delivery, and it was up to the nurse to kind of lead them along as to what to do. I also loved learning from the

> attending MDs and chief residents about different procedures and techniques. I found that I was at a point in my life, totally independent and single, where I was ready for a change and welcomed the challenge of moving up in my field. I chose midwifery, as opposed to going to medical school, because I did not wish to give up the nursing component of care. The natural, compassionate art of nursing is, in my opinion, essential to assisting women with labor and birth. (Andrea, CNM student)

Other paths to the profession, while each beginning with nursing, include Alice's path. She is a retired nurse-midwife, who was affected by "not [being] at all happy with my maternity education. Women were put out, they were sleeping most of the time and the whole medical model." While in Africa, working as a nurse, Alice "learned a lot about midwifery . . . and realized I really liked midwifery." Karen, a practicing CNM, and Patty, a "retired" CNM currently providing gynecological care, were both influenced by instructors in their respective nursing programs who introduced them to midwifery. Tracey, a practicing nurse-midwife, was an instructor in a nursing program who was encouraged by the administration to become certified in midwifery. Bridget, also a currently practicing nurse-midwife, became a midwife in order to be a "change agent." While working an obstetric rotation in a hospital, Bridget was "saddened by the fact" that women were eager for information and ready to make a change in their lives, but that the opportunity for and making change was often wasted by busy hospital staff. Finally, Brenda was a nursing student in maternal and infant health in the 1950s. The director of the program wanted to change the program to nurse-midwifery. Of the four students in the program, only Brenda opposed the change because, at the time "there was nowhere to

practice, except in the mountains and oversees." In the late 1970s and early 1980s, Brenda was instrumental in starting a nurse-midwifery master's degree program in Florida.

Books, Birth, and Better Care

Samantha stands out among nurse-midwives in this study because, in the context of how she became a midwife, she does not identify at any point as a nurse (although she does in other contexts). For her, her own birth, a book, and feminist ideals influenced her decision, while creating a biographically specific work narrative:

> Well it was, I had a child and I just thought it was the coolest thing that ever happened to me. And it was very, very marvelous. And so, then I started reading more books about childbirth and as I read more about different options, I was real young, the first child I had, I was 19. But I started reading all these books and read about midwifery and, you know, I started reading more about feminist approaches to taking charge of your own healthcare. I think that the book that inspired me was *Immaculate Deceptions*. So I decided with my next child that I wanted a midwife. There were no midwives. I was in Virginia, in Roanoke, Virginia and this was in 1978. And there were no midwives at all. All I could find was a small group of people who were like gonna do their own babies at home by themselves and I didn't feel comfortable with that. So I decided there needed to be midwives and started going into midwifery then. But it was mostly the birth of my child. I just thought this is like an incredible miracle and I want to be around this. (Samantha, CNM)

Samantha first identifies as a birthing woman. Next, she shifts into a story of being a consumer of alternative knowledge, reading books and ideas about feminist health care. She cites a lack of available services and a discomfort with unassisted home births, the only alternative at the time, as a reason for choosing to go into midwifery. She finishes her narrative by returning to the birth of her own child--"this is like an incredible miracle and I want to be around this"--to make sense of her decision to become a midwife.

Stacey, like Melanie in the beginning of this chapter, had a negative hospital experience and "wanted to provide care to women so that someone else didn't have to suffer the humiliation I endured." Also, like Melanie and like Samantha above, Stacey refers to a book she read as being instrumental in her decision to become a midwife. The book she mentions is one that several of the women in this study referred to as "the midwife's bible:"

> I was 18, in my freshman year of college and had some serious gynecological issues arise. I got some good references from a friend, but I also went to the library and found a copy of *Spiritual Midwifery*. As corny as it sounds, it was like a light went off in my head. I knew right away I wanted to go to nursing school and pursue this route. The gynecological issues were handled poorly from the doctor who treated me and I wanted to provide care to women so that someone else didn't have to suffer the humiliation I endured. I got better care from nurses and nurse practitioners than from an MD. (Stacey, CNM student)

After describing her desire to help other women avoid experiencing what she did, Stacey makes a distinction between the care she received from nurses and from a doctor, with the nursing care being superior in her opinion. This lays the groundwork for her eventual identity as a nurse, and more specifically a nurse interested in labor and delivery and maternal and infant health:

> In nursing school, the only thing I ever liked was my labor and delivery rotation. Upon graduation, I immediately became employed at [local hospital] in the labor and delivery ward. I had to rethink my plans only once. I actually have my master's degree in women's health because I had a new baby and was recently divorced, and I knew I wouldn't be able to take the necessary call needed for the midwifery program. Now my kids are older, my parents live next door, and I live with a wonderful man who is very supportive. My current employer approached me about returning to school for this certificate, so I jumped on the opportunity. (Stacey, CNM student)

Stacey, again like Melanie at the beginning of the chapter, cites family responsibilities to make sense of the career path she chose. While she may have wanted to go directly into midwifery, as a single mom she was not able to "take the necessary call needed for the midwifery program." Now, in the midst of pursuing a midwifery certificate, she once again refers to family, but in a different context. Where family once prohibited her from pursing midwifery, her current family arrangement makes it possible for her to do so.

Casey, another CNM, is no longer "catching babies," but works providing well-woman care in a couple of different settings. She, too, starts her story by referring to a book. The book she came across resonated with "how I knew I'd have a baby; it was home and it was natural." From understanding how she would want her own birth to happen, she moves to the thought that "this would even be neat to do:"

> Well really, I was a, I had a friend who was pregnant in Austin, Texas, probably back in the 70s and she was showing me this book called *The Birth Book* by Raven Lang and it just captured me. I remember looking through it and I thought, "This is really how I know I'd have a baby, it was home and it was natural." And then I thought, "I would, this would even be neat to do." (Casey, CNM)

We then can hear Casey thinking "about going back to nursing school to become a midwife," but her plans were delayed by her own pregnancy. In her search for a midwife for her own birth, she joined a group of midwives practicing underground. The group she refers to includes several midwives in this study, some of whom eventually became licensed midwives and some who stopped practicing when the laws changed. Casey is one of the few women in this group who chose the nurse-midwife route:

> And at that time I just had a bachelor's in social sciences and many years past. And then I, I don't really remember really thinking, I thought about going back to nursing school to become a midwife and then I got pregnant and started looking for a midwife myself, and then got connected to some midwives here in town, because we had just moved here. And then as soon as I met them, I said I want to do what you do and they said, well you can come with us to prenatals. So, there were a group of midwives in the, this was in 1980, and they would weekly do prenatal care in somebody's house. And I guess I kind of joined with them and started just going to prenatal care and home births. At the same time I went back to nursing school with that in mind of doing nurse-midwifery though. I think I just intuitively knew that would, for me, give me more opportunity than doing licensed, there wasn't licensed at the time, but lay midwifery. I wanted, I guess do a more conventional approach because I thought it would make sense in the end. (Casey, CNM)

In her discussion of working with a group of midwives, Casey tentatively claims a collective identity, "and I guess I kind of joined with them and started just going to prenatal care and home births." She then quickly mentions that she went back to nursing school at the same time because it would give her "more opportunity." In the time period that Casey refers to, nurse-midwifery was the only legally sanctioned midwifery option. Today, licensed midwifery is a legal and viable option for women who want to practice midwifery. Casey told me at another point in our interview that, even today, she "walks the fence," explaining that she and a handful of other nurse-midwives still work very closely and share similar ideas about birth with the licensed midwives. She aligns her identity with both licensed midwives and nurse-midwives, but not with either entirely.

The Future

I asked each of the respondents where they saw themselves in five to 10 years. The following responses come from women who are still actively practicing midwifery.

Andrea, who above said that when deciding to become a midwife "found that I was at a point in my life, totally independent and single, where I was ready for a change," now cites eventual family responsibilities as a reason for expecting to "choose a less rigorous schedule" in the future:

> I do think I'll be doing this in five to 10 years, though I may choose a less rigorous schedule or perhaps be working part-time. I am getting married in May 2000 and plan to stay home as much as possible to raise my family. I plan to stay abreast of the latest in obstetrics and midwifery so as to not let go of it completely and find it difficult to re-enter after being away for awhile. I also wonder where nurse-midwifery will be in five to 10 years. With managed care taking over, its fate could go either way. Though we are more cost effective and yield higher patient satisfaction, we must practice under a physician thus adding additional cost to a practice. (Andrea, CNM)

After suggesting that she may choose part-time work in the future, she shifts from a discussion of the personal to a discussion of health care issues, connecting biographical particulars to broader narratives. Wondering not only what she will be doing in five to 10 years, but also what the state of midwifery will be at that time, she calls upon cost effectiveness and patient satisfaction to legitimate the practice and profession of midwifery. Yet, the downside is that nurse-midwives are not independent practitioners, and because they must be under the supervision of a physician, the cost increases. Andrea's concerns with the ambiguous state of midwifery in the context of managed care are in-line with others in her field (Williams 1999). So, while Andrea portrays her future decision to work part-time and raise a family as being under her control, she has very little control over the future of the profession in general, making this less her own story than the story of women in her circumstances.

At the time of the interview, Samantha was working in two different settings, both part-time. She hopes that in the future she will be doing full-time work. In describing this desire, she struggles with the pros and cons of both full-time and part-time work:

> I'm looking for something, well I'm open to something a little more full time now. I like my job except that there's no continuity of care. Like I see, when I go to the same health department I see the same women, but I don't deliver people that I know. And I've found it more rewarding to have a job where I would do their prenatal care and do the delivery to the same person. It's hard to get a job like that where you don't work too much. Like, it seems like you either have a job with really great rapport with your patients and you work *all the time*, or you have a job where you really don't have a lot of continuity but you have great schedules. My job I had in [neighboring town] was kind of somewhere in the middle. And the job I have now, I have less continuity than I'd like to. I'm open to finding something different. (Samantha, CNM)

The issue Samantha struggles with is an interesting one. Continuity of care is something that is very important in a midwifery model of care. Samantha aligns herself with this philosophy: "I've found it more rewarding to have a job where I would do their prenatal care and do the delivery to the same person." However, she also alludes to the fact that she does not want to work "all the time." Following this discussion, Samantha adds, "In 10 years I might want to not do deliveries anymore. Just because, you know, two o'clock in the morning gets old." Time becomes an overarching theme in Samantha's narrative, but yet there is a tension between personal time and level and quality of care she provides for her patients.

Career? Job? Service? Calling?

Initially, I was using the term "career narratives" when speaking with potential respondents. Among direct-entry midwives, as we will see in the next chapter, I began to

hear a strong resistance to the term "career." This distancing from the concept of career also has been noted by Garey (1999) in interviews with nurses in the context of "weaving work and motherhood." Slater (1976(1970)) described this same phenomenon, arguing that the term career was associated with men, created by and for men and connoting a demanding, rigorous, all-encompassing occupational path. He emphasized that women want their work to be "meaningful and stimulating activity," full of "excitement, challenge, [and] social satisfaction" (p. 78). Garey (1999) laments that this gendered distinction has seemingly not been erased in the 20-plus years since Slater's description.

While direct-entry midwives resisted the term career, nurse-midwives had more ambiguous feelings about it, a seemingly minor terminological distinction that speaks loads of narrative difference. When phrasing my question, I listed a number of terms, including "career," "profession," "job," and "calling," and asked which term best fit how they see the work they do. Samantha responded this way:

> I don't really care. But I've heard it called a calling and certainly you could, with the same degree of education, you could make more money and work less hours doing other things. You have to love it to do it. But, I don't care what you call it. (Samantha, CNM)

While her response, "I don't care," demonstrates an ambivalence about terms, she cites education, money, and hours as potential ways to define work.

As the following exchange shows, Bridget distances herself from the concept of career, identifying instead as a woman's advocate. She links career with a "corporate ladder" and suggests that by stepping down from a director position, she is not entirely focused on "climbing:"

Lara: If you had to choose between some of these words I'm about to say or another word? Profession, career, occupation, job, calling . . .

Bridget: I don't know what you mean exactly by profession because I think that is a big category. But I really look at myself as a woman's advocate.

Lara: I had been using the term "career" when I talked to people and there were some people who didn't really like that word. So, I've just been interested in how people . . .

Bridget: No. I guess that because to me a career connotes climbing the corporate ladder and that's not, I've been a director of a program, of this program and I'm no longer a director, so that it's really, what is it that you want to do. And I don't believe that's within a career, at least my impression of what a career means. (Bridget, CNM)

While Samantha was ambivalent and Bridget was resistant to the term career, Tracey tentatively embraced it, but ultimately felt that there was no one single word that could sum up the work that midwives do:

> Definitely not a job, definitely not a job in the usual sense of that word. I suppose career is maybe palatable in terms of something I've done to make a living and I've worked at it and had to increase, had to have educational goals to achieve, so I guess in that sense it's a career. Profession, I feel very strongly and proud of nurse-midwifery as a profession and feel that that is what midwifery should be. I know there are those who disagree. But I feel there has to be, there should be that component there. I would probably, if there was some word that would say kind of a calling plus a career plus profession all rolled up in one word, that would probably be, I don't really take offense at the other words, just they don't quite . . . (Tracey, CNM)

Taken together, the hesitation in fully embracing a professional identifier such as career, or a nonprofessional appellation such as job, harkens back to the complexity noted at the start of this dissertation. Across the board, these women's narrative positioning is

not squarely settled at either end of the professional/job spectrum, but exists, in their work narratives, in dynamic relation with the broader work narratives that surround midwifery.

Language, Method, and Rapport

Whether they consider their work a job, profession, career, calling or something else, the clearest difference in the narratives of nurse-midwives and direct-entry midwives is that most of the nurse-midwives begin their stories with nursing school or nursing practice, while the direct-entry midwives have a variety of starting points and tell a more complex story of how they entered the profession. In Chapter Eight, I will discuss the potential consequences of the language and methods I used in terms of the rapport I formed with the different groups of midwives. Briefly, nurse-midwives, having been educated in a university system and receiving master's degrees in midwifery, have typically been trained in standard scientific research methods. For this reason, my qualitative, deductive, interpretive study may have been unfamiliar to them. Asking them to "tell me their *story,*" may not have seemed like *real* research.

In many ways, it makes sense that nurse-midwives would begin their stories with a nurse identity. One must be a nurse before becoming a nurse-midwife. I shared this aspect of data analysis with two different groups of direct-entry midwives (senior students and members of the school's board of directors). Both theorized that nurse-midwifery is more thoroughly "professionalized" and, for nurse-midwives, midwifery is a form of advanced practice nursing. One board member suggested that as direct-entry midwifery becomes increasingly professionalized similar narratives will emerge from direct-entry midwives. Chances are that if I asked these same nurse-midwives to tell me the story of

how they came to be nurses, I would hear very different stories. These stories might much more resemble the stories we will hear in the next chapter from direct-entry midwives.

CHAPTER 5
DIRECT-ENTRY MIDWIVES

While most of the nurse-midwives began their narratives identifying as nurses, the direct-entry midwives had a variety of starting points to their stories, including their own birth experiences, childhood memories, participation in countercultural movements, legal barriers or challenges, and an interest or background in medicine, including alternative medicine. While the narratives of entry told by the CNMs were usually quite succinct, asking direct-entry midwives the question "How did you come to be a midwife?" often elicited narratives that filled seven or eight pages.

Entering the Profession

This chapter, like the last one, looks at the paths these women took to the occupation of midwifery. Here, though, we will hear entry narratives from licensed and empirical midwives. The complexity of these narratives is evidenced in the variety of narrative resources from which they draw, including their own birth experiences, childhood memories, prior medical experience, alternative medicine, legal battles and countercultural involvement.

Birth Experiences

The most common theme to arise in the narratives of direct-entry midwives was their own birth experience. In response to the question, "How did you come to be a midwife," 10 out of 15 women referred to their births. Of the five who did not refer to

their own birth experience, two do not have children and two had their children after they had already decided to pursue midwifery. Often, at gatherings of direct-entry midwives, a typical round of introductions sounds something like, "Hi, my name is Jane Doe, I'm a licensed midwife, mother of three, two of those born at home;" "Hi, I'm Nicky, I'm a doula. I have two children, one a hospital birth and one a home birth." Thus, these women, in their introductions, immediately establish a maternal identity in connection with their work. After observing this type of introduction several times, I thought it was important to ask those midwives who have not given birth how this influenced their work. One response was that male gynecologists, who deliver most of the babies in the United States, have also never given birth. Stella, a direct-entry student claims that she "[has] more experience with babies than some first time parents. So, I think that comes through, I'm told I have a very maternal personality."

Sandra, a practicing LM, offers a more extended explanation:

> After I have a baby, some people will give me credentials automatically because I have a baby, but I think it will also make a difference for me that, which is odd because you know what, one child is not the world of experience in terms of having a child, you know there's so, so many experiences, but nonetheless it's an experience. And so, you know I think that I will also feel more confident about what I know because I'll know it from a personal place. (Sandra, LM)

Laura, a licensed midwife working at a birth center, begins her story by describing her experience as a young woman, new to the United States, and unfamiliar with the health care system:

> I grew up in [European country] and came over to America when I was young, 21, promptly got married, got pregnant shortly afterwards,

> moved to a rural area of Florida, and being a very well-brought up, conscientious young woman, knew that you should get early prenatal care. So, I went down to the local health department and presented myself with my accent, terminal case of naivety, and said to them, "Good morning, I'd like to register with a midwife, I'd like a home delivery please, and I'd like to see about getting prenatal care." And the lovely women in the health department just fell about laughing and called everybody else up and had me repeat myself several times, so they could hear my adorable little accent, and then broke the news to me that there were no midwives in this area of Florida and that we don't do it like that here honey. You come to the health department for your care and then you go deliver at the teaching hospital. That didn't sound like a terrific idea, but it's what I had to work with. (Laura, LM)

Laura's story needs to be understood in a particular cultural context. In many European countries, midwifery and home birth have long been legitimate practices. By referencing her upbringing, she supports and legitimizes her desire to have midwifery care at home, even in the face of laughter by the workers at the health department. However, while becoming a midwife would have been easier for Laura in Europe, she tells us that she would have been a "very different midwife when I came out of it, and I don't think I would have appreciated it." The path she did take was harder:

> And looking back, I mean I grew up in [European country]. If I'd known what I wanted to do when I graduated from highschool, I could have walked right into midwifery training in [European country], no problem. The government would have paid my tuition, paid for my books, and paid me a living allowance. How much easier would this have been? You know, I threw [newspapers] for a year and a half at 3:30 in the morning so that I could afford to go to school, so I could pay for daycare for my kids so I could go to school. You know, the other route would have been much easier, but I would have been a very different midwife when I came out of it, and I don't think I would have appreciated it. And I certainly wouldn't have learned the patience I've learned doing it this way. (Laura, LM)

Discouraged by local birth practices and by the lack of midwives in Florida, Laura continues her story:

> So, I was about three months pregnant at the time, so I started care like that and started asking questions about what kind of care I could expect in a hospital and was really not happy with the answers I was getting. So, then I started reading everything I could get my hands on about midwifery, midwifery in Florida, went to the local lawyer's office and the copy of the Florida statutes and found out how you could become a midwife in Florida. And as the result of that search decided that that was what I wanted to do. The things that I was uncomfortable about with the hospital at that time, which is about now 25 years ago, were things like being strapped down for delivery, in the operating room, nobody was allowed to be with you, you were shaved, you had an enema, you got an episiotomy, the baby had to go to the nursery for 24 hours, there was just no options on any of it. So, we wound up actually staying at home and delivering our baby ourselves. In retrospect, not probably the brightest thing to do. And that was probably the first real step in my journey. (Laura, LM)

Citing dissatisfaction with hospital practices at the time, Laura began to read and seek information on midwifery, specifically how to become a midwife in Florida. It was through this process that she decided "that's what I wanted to do." But, she cites her actual birth at home as the "first real step in my journey." While Laura begins her narrative with a story about her own pregnancy and birth experience, she continues, as we will see later, by retrospectively recalling childhood memories of birth.

Like Laura, Sheila begins her story with her own birth experience, but unlike Laura, Sheila's multiple births are the focus of her story and run throughout the narrative:

> Well, I had my first child 27 years ago. So, in the process of becoming pregnant and realizing that I didn't want to go to a hospital, I became aware of, that I wanted to do it at home mainly, and that I would like to have assistance and I didn't particularly care if it was physician, if it was a midwife, that would be fine. We were in Canada, it was in a very rural area and I didn't know of anybody. And there was a doctor

> practicing in the little town, but I didn't speak to him right away about coming out to the home. So, I had heard about the midwives on the Farm in Tennessee and actually right around that time received a booklet in the mail about the Farm and about the midwives. And the last few pages of the book was about midwifery which was exciting because I thought oh this is exactly what I am doing, I wish I had somebody like that around here. So, they didn't have midwives in the area that we were in Canada. (Sheila, empirical)

Sheila did have a home birth, assisted by a doctor and his wife who was a nurse, but did not get the type of support she was looking for "emotionally or spiritually." This experience sparked her interest in midwifery, but it would be a few more years before she knew she wanted to practice midwifery. She continues her story:

> And other friends in the area started getting pregnant and you know the idea of going to assist with somebody else was formulating, and didn't actually get to do that at that particular time until a few years later. So, it was basically just a process of learning about pregnancy, and discovering the process for myself that I felt like I just started learning about things that really interested me and were really important to women and to myself and that there wasn't a lot of that kind of awareness going on. It was beginning. So it was just kind of getting interested and learning about it. Then I had another son up there and he was born in the hospital because I had rubella, so we weren't sure what his condition would be and until my third child who was born in the Farm, with the Farm midwives then I really decided this is, you know I want to do this, I want to apprentice. (Sheila, empirical)

Sheila's story takes us from Canada with one home birth, one hospital birth, and an interest in midwifery, to Tennessee where she birthed on the Farm, "with the Farm midwives" and decided "I want to do this, I want to apprentice." Later we will hear Sheila talk more about The Farm and the importance to her of being in a countercultural, intentional community.

Unlike Laura and Sheila above, Dawn does not begin her story with her own birth experience, but rather with her desire to go to medical school. After an early disappointment with the experience of working in an obstetrician's office, Dawn continues her story:

> So, I just kind of chunked the whole school thing and didn't know what I wanted to do with my life and met my husband, got married, got pregnant, and had a baby. And that first baby that I had, you know I always knew, I had this thing about hospitals, so I didn't want to be in hospitals, so I looked for or sought out a place where I could birth out of hospital with the assistance of midwives. My dad comes from a family of 16, they were all born at home, so I sought out a midwifery practice and found one. And after I birthed with the midwife for the first time, I knew hey this is what I want to do, this is exactly, probably half way through my labor, through my 24-hour labor, when she didn't leave my side for one minute, and rubbed exactly the spot that I wanted rubbed for 23 hours. Yeah, I knew, I knew then, it was real clear, that's the kind of care I wanted to give related to birth, versus the you know the medical type, OB/GYN type. So, that's when I knew. (Dawn, direct-entry student)

Dawn tells us that during her labor with her first child, as she was receiving care and attention from a midwife, she knew "this is what I want to do." She makes a distinction between "medical type" of care and the type of care she received--"she didn't leave my side for one minute, and rubbed exactly the spot that I wanted, rubbed for twenty-three hours"--and realized she wanted to give. While others have expressed a similar preference for a midwifery model of care, Dawn's decision must be seen in the context of her initial desire to be an obstetrician/gynecologist. The event she cites as changing her mind was while working for a prominent obstetrician in town, "we would come in many mornings and find him passed out in the chairs in his office." So, in addition to seeing a difference in a midwifery model of care and a medical model of care, Dawn

also was turned off from medicine because of the long hours, presumably spent away from family, that she observed in her former job. She always knew she "wanted to have a family . . . So, you know it just wasn't for me."

While each of the stories above tell of home births or midwife-attended births, several of the direct-entry midwives in this study did have at least one birth in a hospital. Lisa had a "really great experience." Christy's first hospital birth was an "okay birth," and after her second hospital birth she met a nurse-midwife who "spent a lot of time talking with me and she was just really cool. And I was like, this person's great, she's talking to me, she's not talking at me, it's just a whole different way of interacting." Carrie had a complicated pregnancy and negative experiences with the hospital staff during her first birth. Her second birth was in a hospital, attended by a midwife and it was "different in the fact that I had support."

Childhood Memories

The second most common theme in the entry narratives of direct-entry midwives involves childhood memories. For two women, their immediate response to the question of how they came to be midwives involved stories of childhood. For three other women, childhood memories were told retrospectively. In other words, after deciding to pursue midwifery, they thought back to childhood experiences that now make more sense to them in light of their occupational choice.

Carrie and Helen both begin their stories with a tale of childhood. Both express an early interest in birth. For Carrie, the desire to become a midwife re-emerges with the birth of her first child:

> Well, it's a long story, but I'll make it short. When I was five-ish, around that age, I saw a TV birth, woman screaming, doctor comes in and catches the baby, and I said I wanted to be a baby doctor. Later found out that you know that's a pediatrician. Then my mom had three children. Single child, only child until I was nine. My brother was born a year later, my sister a year later, my other sister. So, that peaked my interest. But even when the second one was born, I still didn't know how because I didn't go to the birth, wasn't involved in sibling classes, just her belly got big and she had a baby. And I was about 10 and every pregnant woman I saw, "when's your baby due?" All that silly stuff. Then with my own children, my first one brought it up again, that this is what I wanted to do. And at that time it was, what I want to do eventually, I want to be a midwife. (Carrie, LM)

While Helen expresses an early interest in birth, she claims that her interest in midwifery in particular developed in early high school and was further legitimated by reading an article in a magazine about the midwives on the Farm.

> Well, I was always fascinated with and extremely attracted to babies and pregnancy and birth. I was the oldest of all the grandchildren, so about every three years there was a baby born in my immediate family, if not my siblings, my cousins. And my mother, labored at home with my little sister when I was six. And she wanted to have an unplanned home birth because her family didn't support her. So, her intention was to have this unplanned home birth, but my father found out she was in labor, so he carried her off at the last minute. But, that would have been my first birth which turned out to be a footling breech. But she flew right out, so it would have been an uncomplicated footling breech. But anyway, so I think I figured out about early high school years that I was interested in midwifery specifically. I used to get *Parent* magazine, yeah strange. And they had an article on the Farm, and that's where I found out about the Farm. But I had already known about midwifery and already wanted to be a midwife. (Helen, LM)

Retrospective Childhood Memories

After beginning their stories in other ways, three women also recalled childhood memories. Stella's decision to become a midwife was precipitated by an unanticipated

need to change careers. As she thinks back over the circumstances that led to her life change, she also recalls her childhood. She remembers being "inspired through my mom's stories of, she had nine children and eight of them lived into adulthood, she was actually pregnant 13 times." All of Stella's mom's births were natural births. Once Stella really understood what that meant, she "caught at a very early age the reverence for motherhood through her. When I finally realized as a child where those children actually come from, I was like astonished and I always honored my mom on her birthday."

Carol begins her narrative by letting us know that while she will pursue a somewhat linear narrative, her decision to become a midwife was not quite so clear cut. She says, "well, I think directly, because now that I look back on it there was a lot of indirect things that I never put together until after I was about 30 years old." She went to high school, then to college, pursued a degree in medical technology, and then went to work in a series of hospital laboratories. When she "look[s] back," this is what she recalls of her childhood:

> But now, like I said, indirectly when I look back and I think I was the oldest of five kids, so my mom had lots of babies, I'm from a big Italian family, lots of kids. I was a weird kind of a kid that when families were getting together and there were these big reunions and gatherings with gazillions of cousins and everything, I wanted to stay inside with the ladies and hear about babies and look at the babies and play with the babies. So that was an early, early indication of, I would rather have done that than played outside. (Carole, LM)

Earlier we heard Laura's story of her own birth experience. Like Carole and Stella, Laura also "look[s] back" to childhood:

> When I look back at my childhood I can see other things that I go, oh gosh, I should have got it then. Oh, I should have worked out, that's

> why I enjoyed that job. When I was two my sister was born at home in [European country]. And I have, my earliest memory that I have is the standing out by the bedroom door at my grandparents' house with my father behind me, with our ears glued to the door, waiting to hear people cry. And then, I don't remember walking through the door, but I remember being told that if I sat all the way up on the bed, with my feet up and my back on the wall and was very, very careful I could hold the baby, and then being given my sister to hold. When I told my mother about this, she couldn't, couldn't believe that I remembered it, because I was so young. Totally confirmed everything, I mean I knew which room it was, where the bed was, which was not normal. And then she added, oh yeah we called you two in before the placenta was even delivered, the baby wasn't even cleaned up, she was just wrapped in the first towel. And you and your dad were allowed in to see her and then you had to go out while the midwife finished up. (Laura, LM)

After relating this memory of childhood, Laura concludes "it all fit in after I decided that's what I wanted to do." From a very early age, Laura invokes experiential knowledge as legitimation for her decision to become a midwife:

> So, that was kind of, you don't mess with those impressions when you're two. You know, I knew with absolute certainty that babies could be born safely at home, without needing any kind of intellectual proof. I knew it from that experience . . . So, it kind of, it all fit in after I decided that's what I wanted to do. (Laura, LM)

Countercultural Movements and Legal Barriers

Several women describe their participation in the counterculture as significant in their decision to pursue midwifery. I use the term "counterculture" very broadly to include communal living, the alternative birth movement, the hippie movement, and underground midwifery practice. Five of the midwives in this study, including one certified nurse-midwife, reported being involved in at least one of these activities. Many of the same women who entered midwifery through the counterculture where also participants in the legal battles to make direct-entry midwifery legal in Florida.

Sheila reports her desire to live in a communal setting, and suggests that midwifery was the "by-product" of this living arrangement:

> I felt like I wanted to try to live in an intentional community like the Farm. And I felt like it would be really good for being a new family and having a lot of agreement about raising children and just about how you want to live. So, that's why we went and the by-product was the midwifery. (Sheila, empirical)

After moving to Florida, Sheila became involved with a group of women who "formed a loose network cooperative and started doing prenatal care together for women and started to do births together." She took a course in emergency medicine, "because I felt like if we're not going to be on the Farm or practicing and working where there are EMT's and doctors then I want to learn emergency medicine." This group of women practiced together, underground, for about six to eight years, until the law changed. Once the law changed, Sheila opted against becoming licensed and stopped practicing midwifery because the risks under the new law were too high. Practicing midwifery without a license went from being a misdemeanor to being a felony.

Jeanne, like Sheila, describes a communal living environment in which attending births happened primarily out of need:

> Well, back in the, I guess it was the mid-70s, people in my community lived, a lot of people in my community lived communally and where they did a lot of cooperative ventures together like food co-ops and child care and schools and that sort of thing. And so, once in a while when our friends would get pregnant, the women would ban together and do births together. And the women who had the most experience either with having babies or having been to births would kind of take more of the leadership roles. But we didn't really have a midwife. And so, over the course of about 10 years, I go to maybe six or seven births. A little average of one birth a year would just so happen to come my way. And it wasn't that I was practicing midwifery or even

> considered myself a midwife, or really even knew what midwifery was, it was just part of what we all did with each other. And so, in the course of doing that we would learn, we would explore and learn from different books and different people. Of course, Ina May's book *Spiritual Midwifery* was our bible. And basically we didn't have much interaction with uh, what you would call the dominant culture and we just did what we wanted to do and we didn't expect anybody to help us and so we just helped ourselves. And that's basically how I got any experience at all with midwifery. (Jeanne, LM)

In the community in which Jeanne lived, because they "didn't have much interaction with what you would call the dominant culture," attending births became a necessity. Jeanne was one of the women in the community who was called upon to take on this role even though as she insists, "I didn't consider myself a midwife, or really even [know] what midwifery was, it was just part of what we all did with each other." So, here Jeanne establishes a collective identity as a community member rather than an individual identity as a midwife.

Gina also did not start out with the intention of being a midwife. Rather, she claims, "it was a series of circumstances and the subculture that I was growing up in that led me to this." Gina was influenced by the alternative birth movement and several books that emerged out of that period, including *Immaculate Deceptions* and *Spiritual Midwifery.* She claims that knowing she did not want to have her baby in a hospital "probably went along with just the whole hippie movement of that time. I mean we were all like back to land, back to nature, using, studying about herbs, it was all part of the picture." Because Gina had her baby at home without assistance, many women in her community who wanted to do the same thing called on her for support and assistance, and she responded to this. But, she claims, "it really just started with just girlfriend helping

girlfriend more than oh I think I want to be a midwife and I'm gonna go to school for this." Gina and a couple of other women in her community formed a study group and, with the assistance of a nurse-midwife, a chiropractor with midwifery training, and other nurses and doctors in the community, learned about birth. Some women who had been trained as midwives on the Farm moved to Gina's community, and together they attended births and supported each other for several years. But, like Jeanne, Gina states, "we didn't use the word midwife, we just said that we were birth attendants and we made it very clear to people about what we could or could not do."

One woman in this study ended up in Florida participating in the alternative birth movement after having been involved in the women's health movement in the northeast. She practiced midwifery in the underground until she was able to become licensed by suing the Department of Health and Rehabilitative Services. After that personal victory, she became active in attempting to change Florida's midwifery laws. Again, these efforts were successful and in 1982 the Midwifery Practice Act was established in Florida, which required three years of formal education. Another woman in this study was influential in establishing one of the first schools for direct-entry midwifery after the new law. In 1984, the law was reviewed based on a "sunset" provision. Based on this review, licensure was limited to those already enrolled in school. Several women, including three of my respondents, hoped to become licensed under the 1982 law, but all "missed the window of opportunity." Two of these women both had babies during this time and as a result missed the chance to become licensed. One of these became actively involved in changing

Florida's midwifery laws. Once that was achieved in 1992, she was very influential in opening a school for direct-entry midwifery.

Medical Background

Four of the direct-entry respondents had some kind of medical background prior to entering midwifery. We have already heard from Carole, who began her professional life as a medical technician working in hospital laboratories. We have also heard part of Dawn's story who had hoped to enter medical school until she recognized that she wanted to provide a different type of care and realized that the hours of work and time away from family were "not for her."

The two other women who had prior medical training or experience were a nurse and a physician's assistant. The nurse was working at a birth center in the early 1980s, providing labor support and teaching childbirth education classes. The volume at this birth center was high, and there was only one CNM providing care. A doctor convinced this woman to become licensed as a midwife under a law established in the early 1930s. At the time, a doctor signed a document declaring a midwife competent after attending a relatively small number of births in the doctor's presence. The midwife also had to take a test which this respondent called "sort of a joke." Another respondent began her professional life as a physician's assistant (PA) and was disturbed by the hospital practices she encountered during her obstetrics rotation. After moving to Florida, she began working with others who were involved in home birth. The doctor she was working with eventually left the state, and left her without legal means for delivering babies since PAs must work under the supervision of a physician. She attempted to become licensed as a

midwife under the same 1930s law that the nurse, described above, had been licensed under, but initially her application was declined by the Department of Health and Rehabilitative Services (DHRS). She sued the DHRS, won, and continued working for legal midwifery reform.

Alternative Medicine and Doula Practice

Sandra, Nadine, and Carrie each cited an interest in some type of alternative medicine as being influential in their decision to pursue midwifery. After leaving a career in public policy work, Sandra spent time traveling, taking classes in storytelling, painting, and weaving, and eventually became interested in the conscious death movement. She says,

> I pretty much went from reading about death to reading about birth and the issues were just so parallel in terms of, so called patient rights, but really human rights, you know, in terms of having it be a dignified experience . . . After I read about the conscious death movement a bit, I went on to reading *Spiritual Midwifery* and based on that decided that I wanted to be a midwife. (Sandra, LM)

Nadine had always had an interest in alternative medicine and massage therapy. In college, she became a women's studies major. For her, midwifery was "like putting together my interest in alterative medicine with my interest in women's issues." Carrie, after deciding to pursue midwifery, first became licensed as a massage therapist, hoping to make enough money to pay for midwifery school. She had learned of a direct-entry midwifery school from an acupuncturist for whom she worked as a nanny. Unable to support herself through massage therapy, she turned to doula practice.

Carrie was one of five women who referred to their experience as a doula, prior to becoming a midwife. Barbara provided labor support services at a birth center before becoming licensed as a midwife. Carole began teaching childbirth education classes in the hospitals in which she worked as a medical technician. The students in her classes often asked her to be with them at their births. After doing that for awhile, Carole learned about doula certification and became one of the first doulas certified by Doulas of North America. Sandra spent more than two years as "what most people call a doula, but I call a labor support person," before pursuing midwifery. Finally, Lisa spent more than 15 years informally providing labor support for friends and family before becoming formally trained as a doula and opening a doula business with a partner. Unfortunately, even with a grant from Healthy Start, Lisa and her business partner were unable to make even enough money to cover the costs of their business.

The Future

I asked each of the respondents where they saw themselves in five to 10 years. The following responses come from two women who are actively practicing midwifery and one woman who has "retired," from practice, but continues to teach and be involved in the midwifery community. Like Andrea, the CNM in the last chapter, Sandra also mentions starting her own family in the future and the impact that might have on her practice. She also ponders other factors:

> Yes, I do, I do. I think I will be doing it in five years, and I think I will be doing it in eight years. In 10 years, I'm not sure, it really depends on, it depends on how, how much support I'm able to build for myself in my community of midwives, in my colleague world. And it depends on, I don't know, it depends on family life, you know we'd like to

> have kids, I don't know you know what kind of impact that will have on the practice. I can imagine that in 10 years, I'd either want like a serious sabbatical (both laugh) or I'd want to shift a little bit. So, yeah, I don't know. (Sandra, LM)

While she sees herself continuing to practice in the immediate future, thinking about 10 years from now, Sandra recognizes the need for support and establishing herself in a community of midwives. The ability to build this community and support will depend in large part on the state of direct-entry midwifery education and practice over the next few years.

Laura also expects to continue her practice for quite a few years, yet being in a very different place in her life, older with grown children and grandchildren, than Sandra she draws upon different narrative resources to make sense of her long-range plans.

> Five years definitely, 10 years most likely. Although gosh, it's taking longer to recover from staying up all night than it used to. And I really do have to get back to yoga classes soon so I can sit in all those weird positions and not be stiff afterwards. You know, there's definitely things that get harder as you get older. You know, I'm 47 now, so I figure I've got a good few years left. Some of the old granny midwives just worked until they were way up in years, up in their 60s and 70s and some of them only gave up reluctantly when their sight started to fail them and they started feeling like they were no longer safe practitioners that they should be. (Laura, LM)

Laura cites age as a potential factor in her decision to continue practicing, "there's definitely things that get harder as you get older." But she also draws on the historical resource of the "granny midwife," to make sense of the fact that she continues to practice, despite "it's taking longer to recover from staying up all night than it used to."

Jeanne is no longer actively practicing midwifery, but continues to teach and expects to continue this for some time. Here she explains why:

> I expect that I'll be doing more teaching. I think that now, at my age and with my experience, and with the way things are going, and I'm very encouraged that there are so many young women that are interested in midwifery, because back when we were interested, there weren't. And for many years we didn't have any interest. So, part of me is glad to see that. Although, I don't know, don't always see the young women that are interested in midwifery going into it for what I would call the right reasons. A lot of women go into it because they think it's a good career opportunity or they think that they're gonna make money on it, or they think it sounds groovy or whatever. I don't really see it so much as a spiritual calling as it was for us. So much, I do see some women that have that relationship to it. But it's becoming more and more professionalized and more and more mainstream, which in some ways is good and in some ways isn't. So, I feel like I need to stay actively involved in teaching so that I can be a link between the modern midwife and the traditional midwife, because I think that's very important and I don't think there's very many midwives out there that actually have a grip on what the traditional midwife is about. (Jeanne, LM)

Jeanne engages in identity work based on generations. Social movement scholars write extensively about political generations, suggesting that they share a collective identity and their collective experiences become a lens through which to interpret future experiences (Mannheim 1952; Schneider 1988; Whittier 1995). Earlier we heard Jeanne discuss how her start in midwifery was firmly embedded in a countercultural context. Here she distinguishes between women of her generation coming to midwifery as part of a spiritual calling and young women entering midwifery today for professional reasons. She cites her role as a teacher as important in order to be a "link between the modern midwife and the traditional midwife."

Career? Job? Service? Calling?

When I began this study, potential respondents would ask what my research was about. Initially I was using the term "career narratives" to describe the data I intended to

collect. However, many direct-entry midwives that I spoke with seemed to express a strong resistance to the term career. This left me floundering for a term to address the issue--work narratives, occupational narratives, or what? Rather than choose a term myself, I decided to incorporate this question into the interviews. I began the question by stating that I had sensed resistance to the term career and wondered how the respondent might characterize the work she does. I would offer terms such as profession, calling, and job. Below are three responses from direct-entry midwives.

The idea that midwifery is a "calling" is often suggested by direct-entry midwives. Even for those women who do not necessarily feel it is a calling, this concept is made available by the larger community as a narrative resource to describe the work of being a midwife. Sandra begins her answer with a reference to the idea of a calling:

> Ya know, some people talk about feeling a calling, I can't say that I ever felt, ya know I didn't grow up in a Christian household, so it's not like I resonate with that word anyway. It's not like I had some kind of experience ever of like, oh now I *feel* called to do this. But, in some ways I find that word appropriate in that it, it's so definitely far from a nine to five routine, where you are essentially responsible for, you know where there may be a lot of stress but essentially what you produce is of no particular import (laughs), it's so not a job. Calling does the job for talking about what it is, in that it respects that it's something that comes from your heart. So, I don't know what I would call it, I guess I don't have a word. Profession is too, I just object to that in all kinds of ways, and same with career. It has a very like you know kind of tracking kind of feel to it. (Sandra, LM)

Sandra distances herself from the religious connotations of the term "calling," but later redefines the concept as "something that comes from your heart."

Sandra rejects both the term career and the term profession. Stella, on the other hand, begins by calling what she does a "service," but quickly embraces the term profession:

> I see it as a service. I know that's like not very glamorous and, but I see it as a service. I also have to look at it as a profession. Because, I'm being, you know the state is, the taxpayer is paying for my tuition. I'm being vocationally rehabilitated and so, I don't see myself as, I mean I see myself as a worker or a, I don't know how to explain it. I just see it as a profession that is in its infancy and I've always tried to keep my professional life and my personal life like separate, and those ethics that I have aren't working in this arena. You can't, I mean I'm not gonna move in with my clients, but I have to meld it somehow, I have to, because you're in a very intimate relationship with them and so, and it's very hard to concept that I'm getting paid for this kind of intimacy. . . . So, I don't have any problems with calling it a job or profession or service and I'm proud of it. I'm proud to say that's what I do for a living. It's taken me a while to say it. (Stella, direct-entry student)

While Stella is comfortable with a variety of terms to describe what she does, she problematizes the concept of separating personal and professional life. She mentions the intimate nature of her work and her struggle to comprehend that she is "getting paid for this kind of intimacy."

When phrasing this question to Christy, I said, "I've heard calling, career, how would you characterize, in that sense of work, what you do?" She, like Tracey, the CNM in the last chapter, says, "well, I mean it's all those things I guess, to me." She continues, expanding and contextualizing the definition of her work:

> I mean it's, sometimes it's a job even. I mean when I'm on the phone with the insurance companies, it's a job. When I'm watching that woman and I'm just amazed at how she's progressing and how things are going and I'm watching all that, it's more like a calling or a passion. (Christy, LM)

Christy distinguishes between the different roles she plays in her work. Her definition of what she does depends on the aspect of work in which she is engaged. She continues, struggling, like Stella above, with the issue of separating personal and professional life:

> I mean I've, I feel so fortunate to have found this because I've always wanted that whatever work I do in my life would be meaningful and to come from something I believe in and am passionate about and not to feel too much like work. And that's what this is. But I know there's people who, well it has to be a calling, or it has to be this. Well, it has to be whatever you need it to be. I don't think, I think you could probably be a really good midwife and consider it your job. And maybe for you and the person that you are you need that little bit of distance from it to call it a job. It demands a lot of you, it demands a lot of you emotionally, it demands a lot of you in a lot of ways. And maybe some people's way of coping with it is to consider it a job and think of it more in that respect you know. But, I mean I think the cool thing about midwifery and what makes it an art is that you bring who you are to it so much that we have to allow for all ways of dealing. I think there can definitely be problems come about by people thinking of it only as a job. That may have its ramifications and repercussions, but so can someone who's so embedded, and their whole life is so embedded in it that who they are is so tied up in it and they don't have anything outside of that, you know what I mean? So, I mean, I think you call it whatever you want to call it. I mean there are people who come, you know they're doing the Lord's work when they're doing midwifery. You know, I feel like I'm doing feminist work, you know when I'm doing midwifery. There's space for all of them. I mean there's Christian midwives, and then there's pagan midwives. (Christy, LM)

Christy suggests that midwifery should be "whatever you need it to be." She also recognizes that it is different things for different people. At the same time that she claims a feminist identity in her work, she also recognizes that some people are "doing the Lord's work when they're doing midwifery." Feminism can be used to legitimize the work as can religion.

Conclusion

In this chapter and the last, we have heard narratives of entry from both certified nurse-midwives and direct-entry midwives. While the nurse-midwives tend to initiate this narrative at the point of nursing school or practice and with the identity of nurse, direct-entry midwives invoke a variety of entry points, and thus a variety of identities. The most common identity invoked by direct-entry midwives in their entry narratives is that of mother. However, alluding to one's own birth and maternal identity is often only a starting point. These narratives tend to be a complex web of childhood memories, legal battles, countercultural involvement, and interest or background in medicine or alternative medicine.

As far as the futures that these women see for themselves, nurse-midwives and licensed midwives both cite personal factors, such as age and family situations, as well as "state of the profession," factors as being determinants of whether they will continue practicing or working in the same manner as they are now. Also, as far as the preferred terminology for the work they do, there is overlap between nurse-midwives and direct-entry midwives, with direct-entry midwives being slightly more resistant to the term career.

Clearly, their stories complicate related work identities by incorporating both biographical particulars and midwife-specific discourses of legitimation, something which a narrative approach brings to the fore. These women are not merely "catching babies," but construct the activity from the standpoint of diverse senses of who and what they are and what this means. The idea of "the" midwife, as distinguished as that term is legally,

still does not bring forth the narrative differences in place, something which I expand upon in the next two chapters.

CHAPTER 6
IDENTITY WORK AND MEDICINE

In tracing the history of midwifery, we see a clear tension with medicine. In feminist and social scientific critiques of the medicalization of childbirth, there is a distinct polarization between the medical and the midwifery model of care. In this chapter, I show that while there is an inherent tension between a biomedical discourse and the discourse of midwifery, in practice the biomedical model is not simply an oppositional framework used for the discrediting of a holistic approach. Rather, it is a discursive resource that can be subjectively used for the crediting of the midwifery profession.

Robbie Davis-Floyd and her associates (Davis-Floyd et al. forthcoming 2002; Davis-Floyd and Davis 1997) conceptualize midwifery today as moving more fluidly within and making use of the medical system when necessary. Similar to the argument I propose, she conceptualizes the phenomenon as "postmodern midwifery." Davis-Floyd et al. explain that

> midwives who fully understand [their own ethno-obstetric system and that of bio-medicine] in a relative way, as different ways of knowing about birth, discrepant systems that often conflict but can be complementary. Ideally, the postmodern midwife knows the limitations of and strengths of the biomedical system and of her own, and moves fluidly between them to serve the women she attends. She plays with paradigms, working to ensure that uniquely woman-centered dimensions of midwifery are not subsumed by bio-medicine. She is a shape-shifter--she knows how to subvert the medical system while appearing to comply with it, a bridge-builder, making alliances

> with bio-medicine where possible, and a networker. (Davis-Floyd et al. forthcoming 2002:2)

In the following analysis, I discuss three specific ways that midwives use a discourse of medical collaboration in constructing a legitimizing narrative of midwifery. First, it is used as a contrast device to set midwifery practice apart from the medical establishment. Second, the discourse is employed in the description of the midwife's daily work, building bridges with the medical community while having the "best of both worlds." Third, I suggest that midwives use this discourse of collaboration to establish themselves as the professional equals of physicians. This is done by characterizing aspects of their work as the "same as doctors" and by describing the process of nurse-midwives training medical students in labor and delivery. This last circumstance is a particularly interesting turn considering the 19th century campaign by physicians to de-skill and eventually eliminate the practice of midwifery. Taken together, these usages show that midwifery stands in no clear narrative relationship with the discourse of medicine.

The Biomedical Model as a Contrast Device

The midwives interviewed often made use of the discourse of medical collaboration to show what they decidedly are *not*. In the following discussion, two direct-entry midwives and a nurse-midwife distance themselves from the medical establishment, creating a sense of legitimacy in contrast to what they consider a less legitimate enterprise, "mainstream medicine."

Sandra is an independent, licensed midwife with a home birth practice. At the end of her interview, I asked if there was anything else she would like to add. Sandra talks of

the political direction that direct-entry midwives in Florida are taking. She is concerned that many people do not realize the potential consequences of mainstreaming the profession. Listen as she describes the costs:

> And sometimes I think that Florida midwives are really loathe to recognize what the price is and to stay cognizant of like what are we paying for this and is it worth it? Like let's keep checking in with that because the desire to reach women is so strong here and to be legal and get the benefits of that so that nobody can harass you, arrest you, so that you can, at least in theory, transfer your patients without a hassle, you know without the fear of like going to jail. But the cost of that is that we run the risk of being made to practice by the standards of practice which are the dominant standards which are the very ones that we are trying to get away from for a very good reason. I mean, by their own obstetrical studies, published in obstetrical journals, obstetricians do not practice scientifically, we do. You know, we're the ones who don't do continuous, electronic fetal monitoring, who don't do routine episiotomies, who don't do routine IVs, even though *their* journal literature says over and over and over again that they will put you at higher risk for C-sections and you know bad babies and for bad outcomes for mothers, blah, blah, blah, they don't practice that way. (Sandra, LM)

Sandra first distances midwifery from medicine by explaining that "the cost of that is that we run the risk of being made to practice by the standards of practice which are the dominant standards which are the very ones that we are trying to get away from." Here she refers to a dominant medical standard which historically and theoretically is in polar opposition to a traditional midwifery model, yet with increasing standards for education and licensure, the two, according to this respondent, run the risk of becoming virtually indistinguishable. The second distancing strategy she uses it to employ a language of "us and them" when she says that "by their own obstetrical studies . . . obstetricians don't practice scientifically, we do." In this statement and what follows, she problematizes the

practice of science by claiming that physicians do not practice scientifically, but midwives do. She describes a situation in which obstetricians' reliance on and hypervaluation of technology makes them scientifically irresponsible.

While Sandra uses the idea of "standard of medical care" as a cautionary tale, suggesting that that is exactly what direct-entry midwifery wants to move away from, Laura, also an LM, takes a different direction with the idea of "standard of medical care:"

> We've got to be doing standard of medical care and the only way that you're going to do that is by having an academic background. So, we're kind of caught. You can't be legitimate on one hand and still be traditionally based on the other. So, what the school is trying, what the [school name, includes the word traditional] is trying to do, as shown by its name, is preserve that kind of traditional basis, not turn it completely into academic and medical model care, but to preserve the traditional components of care with the personal relationships, the education that midwives do with their clients, and seeing pregnancy as the state of health rather than a disease state. So, trying to keep those traditional components whilst being current with what's going on in the fields of medicine and current with what's going on in practice. So, it's a balance. (Laura, LM)

Laura begins with the same idea of standard of medical care, but speaks of it in a more positive way than Sandra. Laura is also contrasting a medical model of care with a more traditional midwifery model, but, similar to the notion of the postmodern midwife (Davis-Floyd et al. forthcoming 2002; Davis-Floyd and Davis 1997), she suggests that balancing the two is important for midwives today. She calls upon medicine and education to legitimate midwifery today, but also invokes tradition to legitimate her own identity as a midwife.

Andrea is a recent graduate of a nurse-midwifery program, currently working in private practice with two physicians and two nurse-midwives. She remembers her training this way:

> Once I began training, I was disappointed in how much medicine interferes with midwifery. I've learned that this profession requires a constant battle to survive and remain autonomous. The natural practice of midwifery is very difficult to practice in a policy-ridden private practice and hospital setting. I understand the desire to deliver in a hospital, I would choose the same. However, I do not agree with being strapped to a bed, poked and prodded, starved, and being treated as though one's labor is an illness which must be treated in a timely manner. (Andrea, CNM)

Whereas Sandra is a home birth midwife and thus is physically separate from doctors, Andrea is a certified nurse-midwife who is in practice with physicians. Physically, she shares space with doctors. She begins her narrative separating midwifery and medicine, to some degree, by claiming that "medicine *interferes* with midwifery." Yet, using the language of battle, she brings midwifery and medicine back into the same space, a conflictual space. She ends her narrative by contrasting the "natural practice of midwifery" with various hospital practices. While bio-medicine and midwifery share narrative space, both respondents also work to create boundaries that distance or separate themselves and the profession of midwifery from medical practice.

The Daily Work of Midwifery

The midwives also used a medical discourse to describe and attribute meaning to their daily work. Particularly, direct-entry midwives find themselves attempting to build bridges with the medical community when they are starting a new practice, for the good of their patients, and simply as a means of maintaining a professional practice. Nurse-

midwives must work collaboratively with a physician. Many nurse-midwives consider their relationship with the physician to be a team relationship. Because these physician-midwife relationships are already well established, there is little need to do the bridge-building work that is described below. The excerpts in this section therefore are primarily from interviews with direct-entry midwives.

Building Bridges

Nadine is a licensed midwife who at the time of the interview was waiting to move, with her family, to another state,[8] before starting a practice. In the course of the interview, I asked Nadine where exactly she sees herself, in terms of her work, five years from now. In the following interview extract, she describes the efforts that she foresees in establishing a practice.

Nadine:	So, in five years, I would love to have like an active birth center. But, I think, for the place that I'm moving to, that will require really building a lot of bridges with the medical community. Because they're not really very good right now. So, there's a lot of like ground work that has to be done first.
Lara:	Is that something that you work, like learn about in your training, in school? *How* to build those bridges with the medical community?
Nadine:	Mmmm-hmmm. Yeah, we have one whole course in, well we have courses in politics on how to change the laws and stuff and then we do have one whole class in collaborative management which is like how do we work with doctors and hospitals and other medical professionals. And even within that we, we put together a packet of this is what I would present to a doctor when I'm asking him to be my backup. (Nadine, LM)

[8] This respondent was moving to a state in which direct-entry midwifery is legal and regulated by documentation.

Nadine's response demonstrates her understanding that "building a lot of bridges with the medical community" will be important to her midwifery practice. In the responses that follow, we will see midwives' recognition that a positive relationship with the medical community is a vital aspect of midwifery practice and that it is particularly consequential for the patients. Nadine explains that the development of this relationship is a foremost concern in the initial establishment of a practice. She follows by explaining the preparation she received in school for establishing and maintaining this relationship.

Jeanne is a recently retired licensed midwife. She continues to teach midwifery students in classroom and in clinical settings. Jeanne sees herself as a "link between the modern midwife and the traditional midwife." She describes her concerns with the mainstreaming of midwifery in this way:

> But it's becoming more and more professionalized and more and more mainstream, which in some ways is good and in some ways isn't. So, I feel like I need to stay actively involved in teaching so that I can be a link between the modern midwife and the traditional midwife, because I think that's very important and I don't think there's very many midwives out there that actually have a grip on what the traditional midwife is about. The traditional midwife in my world view is a shaman in her community. She's not just a medical resource. To me, birth is not a medical event. It's a life event, it's a body event, but it's not a medical event. (Jeanne, LM)

Jeanne contrasts midwifery and medicine, saying that the midwife is "not just a medical resource."

When asked about her professional relationship with back-up physicians, she explains her alliance with the medical community in the following manner:

> Well, that's actually what I teach at this school is how to have a good relationship with back up. And it's kind of interesting because me of all people, you'd think I wouldn't interact that well with the medical community, but I do. I was very well respected and I had a lot of good help. I had nurse-midwives that worked with me, doctors, I had two back-up doctors in the course of my tenure practice. The first doctor I had for about six years maybe, about half each, five and five. And one of them had a nurse-midwife who worked with him and that was really great for me. And then I had many other doctors that I used as needed, you know high risk docs, ultrasound, diagnostic docs, family practice docs, you know all kinds of doctors that I worked with. (Jeanne, LM)

Jeanne begins by establishing that she has a "*good* relationship with back-up." However, immediately following this statement she gives a disclaimer that although no one would expect her to have a good relationship with the medical community, she in fact does. One might have these expectations about her because, as she admits earlier in the interview, "the dominant culture does not please me, so if I am becoming more and more a part of the dominant culture, then I am less pleased with myself." If one associates the medical establishment with dominant culture, then one would expect Jeanne's story to follow a path leading away from the medical establishment. Instead we see Jeanne describing relationships with doctors and nurses throughout her years of midwifery practice.

Carol is a licensed midwife with an independent home birth practice serving two large, rural counties. In the following excerpt, she describes what is likely to happen interactionally when she has to transfer a patient to the hospital during the birthing process:

> Obviously people come to you for a home birth, they really want to have a home birth, you want them to have that. So, when something

> happens and things change and you have to go, it really is a really stressful time. It's sad and sometimes it's scary, it's really hard. And midwives especially, especially direct-entry midwives with no previous hospital interaction are really stressed out and really uncomfortable and it's very much out of their element. And I've just heard that over and over. But for me it's really the opposite because I can go in there and know exactly what's going on, and I hate to say it, but it's like how you play the game when you get in there. And I do that really just for my clients, because now that everything has shifted, I still want it to be as good of a birth experience, even though I know it's gonna be very medicalized, so I try to really preserve that, kind of preserve and guard all the relationships, you know I don't want the husband screaming at the doctor. So, I feel like I play a little role of mediator at times, but if it helps somebody's experience, then it's a good thing. (Carol, LM)

While Nadine and Jeanne speak of the importance of "building bridges" with the medical community to establish a practice and working with doctors over the course of a practice, Carol expresses a different agenda. She exemplifies the postmodern midwife described by Davis-Floyd et al. (forthcoming 2002), moving fluidly between home birth and hospital settings because she "know[s] exactly what's going on." She tries to ensure that her clients' birth experiences are not subsumed by the medicalization of childbirth that is typical in the hospital. All of this, she recognizes, is important for the good of her clients: "I do that really just for my clients."

The Best of Both Worlds

Like the postmodern midwife described by Davis-Floyd et al., my participants display an awareness of the strengths and limitations of both a biomedical model of care and their own model of care. When necessary, these two worlds can be complementary. Carol, who described herself as "playing the role of the mediator" above, continues by

sharing how she feels her background as a medical technician is an asset in interactions with hospital staff:

> So, you've gotta kind of have both worlds. And then just kind of live in one and be able to float in and out of the other. So, I feel like my whole, I mean after being a med tech for a long, long time and being in hospitals since 1978, I was very comfortable with all of the terminology, the hierarchy and believe me that there is that, and know how to weave myself in and out of that. I didn't have to figure that out. So, I felt like for me I had a pretty huge, I felt like it was a huge advantage. That's just pretty unique. (Carol, LM)

Carol's tale is an intriguing one of technocracy and holism. Based on her story, she is capable of moving between the two frames of reference, "just kind of live in one and be able to float in and out of the other." Carol has the benefit of having been trained under a biomedical model due to past employment at a hospital. This very important knowledge, certainly capital in relations with physicians, provides her with an advantage other midwives do not have: "I didn't have to figure it out. So, I felt like for me I had a pretty huge, I felt like it was a huge advantage."

Laura's story is a bit different from Carol's. Laura, a licensed midwife who earlier spoke of standard of medical care in a positive light, works with a partner in a birth center. In this excerpt, she is asked what she thinks about the direction that midwifery education is taking in Florida. In her response she directs us to the balancing act that must be a part of today's midwives' skills, clearly articulating, at one point, the fight for legitimation, and the need for bio-medical knowledge. Her narrative is a telling one.

> But, it's a trade-off. If we want to be professional, if we want to be accepted in the current mode of care, then we have to have that academic background. We've got to play with the big boys whether we like it or not. And it's kind of like knowing that you have to put on

> panty hose and pumps and makeup to go lobby in Tallahassee or no one's going to take you seriously. We've got to be doing standard of medical care and the only way that you're going to do that is by having an academic background. So, we're kind of caught. You can't be legitimate on one hand and still be traditionally based on the other. So, what the Florida school is trying to do is preserve that kind of traditional basis, not turn it completely into academic and medical model care, but to preserve the traditional components of care with the personal relationships, the education that midwives do with their clients, and seeing pregnancy as the state of health rather than a disease state. So, trying to keep those traditional components whilst being current with what's going on in the fields of medicine and current with what's going on in practice. So, it's a balance. (Laura, LM)

Lisa, a direct-entry student midwife, has worked in administrative positions in hospitals. I asked her if she thought that background was useful to her as a midwife. She responds:

> Absolutely. I think it's given me a lot more open-minded philosophy kind of thing as opposed to some of my classmates who don't, who either had poor hospital experiences or who have not had any hospital experiences and won't even give that an opportunity. Won't even consider that that could be a good experience. Because it can be a good experience, a hospital birth can be a beautiful experience. I've been to many of them. I've been to caesarean sections where the woman's been in four days of prodromal (false) labor and we danced at three o'clock in the morning to UB40 and did candlelight rituals in the front yard at six am, and just spent days and days, and she ended up with a caesarean section and she said she would not have done it any other way. She got to do absolutely everything that she wanted to do. And just because it ended up as a caesarean, doesn't mean that it was not a successful delivery. It was awesome for her. And I am very proud that I got to be her support person. I think, definitely, having seen good hospital births gives me an advantage over people that won't give it a chance. I think there's people that have seen bad home births, you know with poor outcomes that won't give that a chance. And you know, that's not right either. First of all, it's up to the parents, with medical guidance, but also the woman's choice is paramount. And you shouldn't let, one of the first things that they teach us in the structured doula teaching is to put your own values

> aside. And one of the things they teach us in midwifery school is put your own values aside. You can't project what you think is the right thing to do on somebody else, until you get into a medical need situation, and then you say, look this is what's happening, we don't have any options, now we have to take this path. I don't like it, you don't like it, this is what we have to do. But, up until that point, you have to put aside everything that you think and everything that you believe and totally focus on what she thinks and believes. (Lisa, direct-entry student)

Lisa draws upon her previous hospital experience to characterize herself as a flexible midwife. This is what is taught in doula training and midwifery school, and she is able to accomplish it because of her "more open-minded philosophy." In this portion of her narrative, Lisa also invokes two different, yet related legitimizing discourses. She starts by telling a "birth story" which leads into a discourse of feminism or "women's choice." Because a "woman's choice is paramount" in deciding how to birth, it is vital for the midwife to respect that choice and "put aside everything that you believe and focus on what she thinks and believes."

Bridget is a CNM working in a large practice. Toward the end of the interview, she asked me about my research agenda. I explained the research and how qualitative methodology approaches the research project. Bridget continued to probe deeper, obviously intrigued by the research. I spoke of how the social scientific literature divides the technocratic and holistic models of birth. According to Bridget though, it is "not like that:"

> Well, I guess it is where, see my education is not that. My education and how I was introduced and what was, was that the nurse-midwife is on an equal basis in the team. So, really what you're offering the woman, and where I worked at it was a team approach. And so I think, what we can bring to a woman is the best of both, and I can give

> you an idea. The way it worked before was that we met a woman and she was pregnant, her first interview was with a nurse-midwife. So the nurse-midwife did the history, the nurse-midwife also did the first physical. Of that time that was set aside, there was 15 minutes set aside where the physician therefore was introduced to this, anything that the nurse-midwife had discussed or evaluated. And at that point, so the woman knew who her care providers were. It may not be that particular person because of the size of the practice. But it was that she had an idea of the philosophy of the nurse-midwife. And the philosophy of midwifery which is that this is a normal process, but it dovetails with the medical model. (Bridget, CNM)

Bridget argues that her training provided a sense of pride in being a midwife and her place in the "birth team," where each member, the physician and the midwife, are responsible and work in collaboration with each other. According to Bridget, both approaches are necessary and build upon one another, "dovetailing" each other, thus creating a more complete birthing experience.

The Equal of Physicians

Last, midwives use a biomedical discourse to establish themselves as equal to physicians by describing their own work, or the work of other midwives, as similar to doctors. They also place themselves in a cooperative, team relationship with physicians, in which each profession must rely on the other. Further, several midwives describe their experiences of training medical students in labor and delivery. This inverts the traditional hierarchy which places physicians at the top and turns it into a teacher-student relationship in which a student is typically in the more subordinate position. This issue of collaborative practice is an important one in the profession of midwifery. Both midwifery and medical students take courses in collaborative management and the *Journal of Nurse-Midwifery* devoted an entire issue to collaborative practice issues in 1998. This special issue outlined

the characteristics, barriers and benefits of collaborative practice (Keleher 1998) and described the importance of interdisciplinary education and practice (Singleton and Green-Hernandez 1998) collaborative care (Payne and King 1998) and team building (Stapleton 1998).

Doing the Same Work As Doctors

Bridget, who explained her sense of a team approach above, explains what typically happens when a women comes to the hospital in labor. Here she points out similarities between her role and that of the physician she works with:

> Well, remember, this is a practice. So that, not that we know all the women because we don't. We have two practice sites and so, and it is that we ask a woman to call us first so there's a midwife on-call 24 hours. So you may have contacted, this woman may have contacted you earlier and you've discussed, she's telling you what's going on and you offer her to come into the hospital. So you are expecting her. The labor and delivery situation is that the supporting nurses and the staff, they do the same thing for the nurse-midwife as they do for the physician. So, we function very much in that capacity. So that they get the patients ready for us and they'll call us and tell us when she's there. (Bridget, CNM)

Bridget frames her argument within the activities that are part of the "labor and delivery situation," as she puts it. According to Bridget, the staff support the midwife in a similar fashion to the manner in which they support the physician, "they do the same thing for the nurse-midwife as they do for the physician. So, we function very much in that capacity."

Dawn is a student direct-entry midwife, doing her clinical training in a birth center that employs several CNMs. In the excerpt below, she responds to a question about what she sees as the biggest difference between direct-entry or licensed midwives and nurse-midwives. Follow her narrative as she establishes that although the midwife is certainly on

equal footing with the attending physician, she should not be performing the same type of care as the biomedical model demands. The midwife must remain true to the midwifery model of birth:

> So, it's almost like the out-of-hospital birth center is being put on the back burner, and birthing at the hospital with a midwife is now trendy and it's what everybody is doing. And so, okay we have that option, instead of you being with the doctor, you can be with a midwife. Well, what does that mean? It means nothing because if the midwife is in clinic at the time that you're in the hospital laboring, she's not going to be over there laboring with you because you're that hospital's property so to speak, you're being managed by those labor and delivery nurses, and the nurse-midwife is sitting over in the office, first hand experience, sitting over in the office, checking in by the phone, just like the doctor does. And to me, that is just not midwifery, that is not midwifery care. Coming after the woman has labored and you know the head's about to crown, and you come to catch the baby, that's being an OB/GYN, that's not being a midwife. That's not what midwifery is about. Midwifery is about being "with woman" and you can't be "with woman" if you're not present for laboring with the woman. (Dawn, student LM)

Midwives Training Medical Students

Nurse-midwives participate in medical education in over half of U.S. medical schools, typically teaching residents in family medicine and obstetrics and gynecology (Harman et al. 1998). Two certified nurse-midwives related their experiences of teaching medical students about normal birth. This phenomena is likely much more common among CNMs because of their hospital privileges. Samantha is a CNM. She currently works part-time for a state-funded program, delivering gynecological and prenatal services to women in rural counties. She also works part-time teaching medical students how, in her words, "to do a normal birth." I asked her if the students have been receptive to this. She responds:

> Yes. I think medical school must be hell. They throw them in there and they don't tell them anything. I mean they say, read the book and do it. So, I mean and we're talking about delivering a baby. So, when I go in there with someone and I'm practicing with them and showing them, and then I put my hand on top of their hand and say press this hard, this hard, pull this hard, you know pull this hard you know, things you can't read, you can't read in a book how much pressure. And, or I'll do a pelvic exam and say, it's a little to the left, you know things you can't read in a book how to do that kind of thing. They are so grateful. They just walk out of that room and they go, wow thank you so much, you're so patient, you're so kind. And you know, you just know no one has held their hand and led them along at all. Whereas midwifery school is really different. There's someone with you, showing you that. And you know I'd rather people learn by me sharing my knowledge then have them have to make all my same mistakes. You know? It doesn't seem like a good process. I don't really understand medical school, why they do that, it just seems cruel. But, they're very grateful. (Samantha, CNM)

Samantha describes the lack of one-on-one teaching that she sees in medical training. She contrasts this to midwifery school where there is "someone with you, showing you." So, while this is in some ways a narrative of collaboration, working with medical students, there is also a contrasting of two different approaches to teaching with the midwifery model prevailing in her story.

Karen, a certified nurse-midwife, has also had the experience of training medical students in the practice of normal birth and here explains the benefits of these types of programs. According to Karen, the training is important for midwifery because it provides the physicians with useful information about midwifery as a profession and introduces knowledge of the birth procedure that they would not have been able to gain in medical school:

> And the more physicians that are coming out of school who have trained with midwives, you know in tertiary care centers where you

> have residents and you have nurse-midwifery students or at least a nurse-midwife practice. There's been that exposure which takes away the fear of the unknown. Nurse-midwives learn the physicians', but you see if you are nurses first, you've already learned the physician game. But for the physicians who have been socialized into medicine, which is a very different society of its own, for them to work next to the midwives, don't have to do anything with them, but they can then watch and see what they do and listen to how they explain things, and watch how they do a birth without using a million tools other than their hands and their voice, it takes away some of the fear and drops some of the barriers there are between these groups. (Karen, CNM).

Grounding the Postmodern Midwife

Davis-Floyd's conceptualization of the "postmodern midwife" proves quite interesting in light of the analysis presented here. Returning to her argument, she, along with her co-authors (Davis-Floyd et al. forthcoming 2002; Davis-Floyd and Davis 1997), suggest that "today's midwives" find themselves balancing a world of nature and medicine. Juggling them, if you will. They do not place the two discourses in opposition, but rather embrace each, inciting a playfulness of identity as they fluidly shift between the two as needed in the everyday narrative pragmatics of midwifery.

In this chapter, I document empirically the theoretical argument put forth by Davis-Floyd. I have noted three specific ways in which midwives work to construct a narrative legitimation through the interpretive blending of technocratic and holistic models of birth. First, the discursive horizons of the biomedical model are established as a contrast structure through which they can legitimate their own work. The second manner is directly in-line with Davis-Floyd's argument, suggesting that midwives use the biomedical model to communicate necessary aspects of their mundane work. Third,

midwives build a sense of medical collaboration in the tales they tell to equate their own work with that of physicians.

In two recent books, Gubrium and Holstein (1994; Holstein and Gubrium 2000a), have argued for a more grounded self than that proclaimed by postmodernism--a "self we live by," as they term it. The postmodern midwife constructs an identity she lives by. She finds herself located at nodal points of communication (Lyotard 1984) where the language games (Wittgenstein 1953) of nature and biomedicine interact. These two discourses, often seen as competing, provide important, interpretive resources for the midwives to construct a sense of identity that legitimates their very work and occupation. Similar to Foucault's (1978, 1982, 1988) later thoughts on the intersection of subject and self, the contemporary midwife is agentic, capable of reflecting on her work and substantiating it in complex ways through the discursive constructs available to her.

CHAPTER 7
IDENTITY WORK AND THE PUBLIC

The previous chapters have examined how midwives frame their identities in relation to their work and in relation to the medical community. Here, I explore this same process as midwives situate themselves in relation to the public. In this context, I present data that show respondents' talk about the public perception of midwifery, the performative work (Goffman 1959) they do to present certain selves to various audiences, and also the ideas they have for changing public perception, including educating the public and utilizing popular media and other means of advertising.

Public Perceptions

In response to the question, "What do you think is the general public's understanding of midwifery?" answers varied, but typically fell into two general categories. On the one hand, midwives invoked historical images of midwifery and used these to contrast midwives today. On the other hand, respondents reported that the public does not know the difference between alternative forms of midwife. In these narratives, midwives are engaged in maintenance of their public identity (Johnston et al. 1994) by negotiating negative public images and reshaping those images to be more positive (Taylor and Whittier 1992).

One empirical midwife, Gina's, response does not fall into either of the categories mentioned above, but rather suggests that the public perception of midwifery is "pretty good right now:"

> Oh, I think it's pretty good right now. I mean you have programs on television that are showing births with midwives, a lot of OBs in private practices are employing CNMs and LMs to be part of their team. You find a lot of nurse- midwives in hospitals, we have lots of birth centers now, never had those before. Most medical students when you bring up the concepts of midwives, like I say well I teach midwives, that's just like, that's nothing unusual for them to be hearing anymore. And 15 years ago it was, it was like a what? What do you do? That. Ewhh. I think midwifery is thriving and people are, just like we have more massage therapy and acupuncturists and homeopathy, all of it now is integrated in the hospitals and people are aware of those words and they don't think anything's unusual about it. Oh, I went to see my acupuncturist today, it's like it doesn't, you know I had a surgeon suggest to me for some surgery, he goes do you know what arnica is, which is a homeopathy remedy, it helps reduce bruising and swelling, and I said yeah and he said good, I want you taking it the evening before the surgery. And he's just like you know a surgeon. So, you know I just think across the board, we're emerging now in our health care. (Gina, empirical)

Gina refers to the representation in the media, the number of midwives working in medical practices and the recognition by medical students as evidence that the public perception of midwifery is "pretty good right now." She further situates midwifery in the context of emerging acceptance of alternative medicine such as massage therapy, acupuncture, and homeopathy. She cites the integration of these practices into the hospital setting as legitimating alternative medicine for the wider public. To give further meaning to the integration of alternative medicine with allopathic medicine, Gina tells a story of a doctor prescribing a homeopathic remedy, "I had a surgeon suggest to me for some surgery, he goes do you know what arnica is?"

Historical Images

Listen to historical nuances evidenced in the following descriptions of public perceptions of midwifery. Sandra, a licensed midwife draws upon an historical image of the South in her comments:

> I'm not sure what the popular view is. But you get that kind of back sweep of like "Oh, you mean like those black granny midwives of the south" and then the whole thing is laid bare of all kinds of things, what we think about black women, what we think about older black women, what we think about the south, what we think about healthcare in the south . . . That gets sucked onto midwifery, I think. So, I think there's a lot of unconscious and racist assumptions that come along with that. (Sandra, LM)

Casey, a certified nurse-midwife, invokes the traditional apprenticeship (experiential) model of passing on knowledge:

> I think they're portrayed as not having medical knowledge. I think they're portrayed still as not educated. Although that's been really pushed to change. There's interviews all the time, and people I know send me articles, I still think the popular culture does not really understand the educational route of a midwife, thinks of her more in terms of experiential, you learned it from your grandmother. (Casey, CNM)

Lisa, a direct-entry midwifery student, recalls the era of the 1960s and 1970s and "the hippy, flower-child:"

> I still think that the general population has a real misconception of what midwifery is about. They're still focused on the hippy, flower-child, giving birth on a school bus mentality. And they don't really understand the advances that have been made. (Lisa, direct-entry student)

In the context of their relationship to the public, these midwives invoke the historical and traditional images of granny, uneducated, and hippy, to distance themselves from these images of the past.

In the above excerpts, we hear midwives distancing themselves from the historical images of midwifery, yet in other contexts, they call up these same images to embrace this past. The following excerpt comes from an empirical midwife who, just prior to this statement, had told the story of one of her most memorable births for which she had to take a canoe to the house of the birthing woman. She says,

> It was like how the Frontier Nursing Service Midwives must have felt going off into the hills and hollers of Kentucky to deliver babies and no one's coming to bail you out, you're just gonna have to deal with whatever happens. Or how our rural granny midwives must have felt. They wouldn't even accept black women at [local hospital], would not allow them in the hospital doors. So they had to take care of it. And statistically, you know everything went well. So, I had a feeling of that more traditional, primal feeling at that birth. So, that one stayed with me. (Gina, empirical)

Gina calls up the historical images of the Frontier Nursing Service and rural granny midwives and links her experience to this tradition. This was one of her favorite, most memorable births and she had "a feeling of that more traditional, primal feeling at that birth." Her identity as a midwife is tied to the past, to tradition.

The next excerpt, from a licensed midwife, is set in a context of the respondent talking about the right and wrong reasons for going into midwifery:

> It's a natural realization of your role in the community to begin with. If you are a respected, strong woman in your community, then women will want you to be there when they have their babies, because that's the kind of time when they want a woman of your stature to be with them. When they have their babies, when they get married, when they

> die or when someone in their family dies. Those were the times when traditionally midwives were called upon to serve their community. My community still calls me, very much so during those times and I am often called to attend people when they're dying as well. That's not something I advertise, it's not even something that I put out there, I just, that's what assures me that I am a midwife. (Jeanne, LM)

Here is another example of a respondent embracing the image of the traditional midwife and invoking this image to establish a framework for her own identity as a midwife. Her community calls on her in that same way that communities called on traditional midwives and "that's what assures me I'm a midwife."

All the Same

A study conducted by nurse-midwives, asking 200 respondents in four states about their perception of midwives and nurse midwives, found a large proportion of individuals who report being uncertain about midwives' and nurse-midwives' level of education, scope of services, and relationship to the health care system (Johnson et al. 1998). The researchers suggest that consumer education could have a sharp impact on shaping the public perception of both midwives and nurse-midwives.

My respondents report a similar sentiment. The following excerpt is Dawn, a direct-entry student midwife's, response to the question, "What do you think is the general public's or the popular understanding of midwifery?"

> I think the popular understanding of midwifery does not understand the difference between CNMs and LMs and CPMs. I don't think they care. You know she's a midwife. And I think that once the profession of midwifery gets to the point that the public is at, where it doesn't matter if you're a CNM, LM, CPM, whatever when we can all just be midwives, then we'll be better off as a profession. Because right now the public's at a better place in their heads than we are. I don't think the average Jane or Joe on the street cares if you're a CNM or an LM

> because they don't know what's behind it, they just know that you're a midwife, and they just know that they like you and they just know that they want you at their birth. (Dawn, direct-entry student)

Here, Dawn frames her story as one of the public's misunderstanding of the difference between different types of midwives. Following this she alludes to the tensions within the profession of midwifery (debates and disagreements as to whether nurse-midwives and licensed or direct-entry midwives should be united under the umbrella of one political organization). She uses this debate to establish herself as one who believes that the boundaries should not be so starkly drawn, suggesting for herself, in this context, an identity as a midwife over and above a direct-entry midwife.

Sandra, a licensed midwife begins her story in a similar vein as Dawn, but takes a different narrative turn. She says,

> There is the sort of vast confusion about the different kinds of midwives there are, the licensed midwives, the nurse midwives, and not that I expect people to know that because you know, why would they care? But, it does make things a little more, you don't really know where you stand when somebody recognizes, "oh, you're a midwife," it's like what's their association with that? Because there's just so many varieties of people now who practice. So, sometimes I get recognition, but the kinds of experiences they've had with their midwives may or may not be reflective of the kinds of experiences they have with me. So, most people who are having midwives are midwives who attend them in hospitals. And very often those are very, very obstetrical experiences, replete with Pitocin and the epidural. (Sandra, LM)

Similar to Dawn's story above, Sandra, also a direct-entry, licensed midwife begins her story with the public's confusion between different types of midwives, yet she invokes a medical model of birth to resist the broader identity of midwife, preferring to be

recognized as a particular type of midwife, one who provides a particular, nonmedicalized, type of care.

Tracey, a certified nurse-midwife, also suggests that the public does not know the difference between different types of midwives:

> I would say, probably a majority see nurse-midwives, or midwives as being all under one category and that their primary function, or their impressions that they do home deliveries only, that more of the "nuts and berries" kind, and into just herbal medicine, total non-use of technology, unless they've had experience with nurse-midwives or know one. (Tracey, CNM)

In Tracey's narrative, as in the two previous examples, we see boundary maintenance taking place. She suggests that most people do not know the difference between different types of midwives, or that they put them "all under one category." She links the public perception of midwifery to home births, herbal medicine, and anti-technology. That is "unless they've had experience with nurse-midwives." While she does not directly mention direct-entry midwives, she only contrasts nurse-midwifery with the characteristics mentioned above, leaving the listener to assume that, or at least wonder if, other types of midwives can be associated only with those characteristics.

Performative Work and Multiple Audiences

Midwives often find themselves "performing" for multiple audiences. At times, they perform for their clients or other people in the community, for doctors, or for politicians, among others. In this section, I use Goffman's metaphors for interaction to analyze the midwives' performances.

Throughout his work, Goffman uses metaphors of both performance and game to describe social interaction. In *The Presentation of Self in Everyday Life,* Goffman (1959) uses the dramaturgical approach to study the organization of social life and social interaction. The basic assumption of this approach is that individuals have an interest in controlling, or managing the impressions that others have of them. The foremost principle in the dramaturgical approach is the performance.

Elements of performance include the front, dramatic realization, idealization, and expressive control. The front encompasses all the costumes and physical props of the social setting as well as personal expression. Dramatic realization occurs when actors infuse interactions with signs to communicate facts that might otherwise be concealed. Idealization is the inclination of actors to present idealized impressions for their audience, forgoing or concealing action that is inconsistent with the idealized standards. Actors depend on expressive control to keep inconsistent moods and energies from interfering with the performance.

Several other important principles of dramaturgy include: discrepant roles, communication out of character, and impression management. Discrepant roles occur when the same individual occupies roles which place her or him in the audience at one moment and in the performer's backstage area in another moment. This poses a threat to the maintenance and credibility of the performance. Communication out of character entails the display of sentiments which are inconsistent with the official performance. When communication out of character occurs, realigning actions are necessary to reestablish the working consensus of the interaction. Goffman outlines techniques of the

'art' of impression management, including defensive practices. With defensive practices, the actor should show loyalty to the performance, be disciplined in attending to the techniques of staging a successful performance, and determine in advance how to best stage a show (Goffman 1959; Branaman 1997; Manning 1992).

In *Encounters* (1961) and in specific essays in *Interaction Ritual* (1967), Goffman uses the game metaphor to emphasize the rules of defining the situation and what aspects of the material environment and attributes of individuals should be meaningful in social interaction. While everyday interaction usually involves relatively safe ritual order, sometimes a specific social interaction involves risk, thus the "play of the game" becomes important. Expression games base interactions on the control of information. The subject makes moves intended to be observed while the observer tries to ascertain the reality behind the observations. The more that is at stake in an interaction, the more likely deception will occur. Another game-like aspect of social life involves "strategic interaction." In this, Goffman highlights his argument that the players must be aware of such things as the opponent's moves; the opponent's intentions to proceed with the game, no matter the cost; the knowledge that each player has about the other's situation; and the opponent's resources; among other things (Branaman 1997; Manning 1992).

Laura, a licensed midwife, describes the costume necessary for the presentation of self in the context of lobbying in the state capital, echoing impression management:

> We've got to play with the big boys whether we like it or not. And it's kind of like knowing that you have to put on panty hose and pumps and makeup to go lobby in Tallahassee or no one's going to take you seriously. (Laura, LM)

In the following story, Julie, also a licensed midwife, gives a more detailed description of the performance and the planning that she and her colleague would put into a performance:

> The first time we were going to Tallahassee, she says oh I'm gonna wear my little gauzy, yellow, hippie dress and I'll bring like a ray of sunshine into the light, into the day for these legislators. I looked at her and I said, that's see-through, you're not, I'm not getting in the car with you going, wearing a see-through dress up to Tallahassee, you've got to dress professionally, otherwise you're just going to be trivialized. I said I'll buy you a suit, we'll go to the second-hand store. I bought her a suit. You're getting in this car and you don't have to put this thing on until we're 10 miles outside of the city. And I wear this [she points to her gauzy, short, bright pink dress] and then 10 miles outside of the city, I change. It used to be that we would get all the way to the capital and we would have these clunky clothes on, but there were so few women in the legislature that we would sneak into the basement, put our traveling stuff in our bags and put on our dress-up clothes and we would be able to then hit the Senate and the House floor. But over the decades, so many more women legislators came to be that you couldn't go into the ladies bathroom and find it empty anymore because there would be women in there who you were gonna see them in their office and you certainly didn't want to be standing there in your cut-offs and running shoes trying to work your way into an ill-fitting pant suit. So, all of that changed over the course of our doing this work. (Julie, LM)

In this story, Julie outlines the defensive practices she and her colleague would engage in prior to performing "professional midwife." Determining in advance how to best stage the show, Julie warns her colleague, "I'm not getting in the car with you going, wearing a see-through dress up to Tallahassee," and proceeds to buy a suit at a second-hand store. They continue their discipline in attending to the performance by searching out a backstage area, "sneak into the basement," in which to prepare for the performance. As more women joined the legislature, and the "ladies room" was no longer a safe

backstage area, Julie and her colleague recognized the potential of discrepant roles or communication out of character.

In the following extract, Karen, a certified nurse-midwife, relates a story in which she engages in expression games and strategic interaction with a group of obstetricians:

> And if you're a young, fit woman wearing a suit, you can't be a midwife. I've done this to obstetricians too. It was wonderful. I had to appear before an OB staff committee with 24 obstetricians at the meeting and I came in a business suit. And I tell you those guys were picking their jaws up off the floor. They had no idea, they had never seen in the flesh a midwife. And they had no idea and they were just stupefied. There were a few of them who knew, you know 'cause I had been invited to come, there were a few who knew, but there were many, many, many who had no clue. (Karen, CNM)

There are elements of performance and game in Karen's narrative as well. She utilizes dramatic realization and idealization by dressing in a way, wearing "a business suit," that the doctors do not expect. This more professional aspect of midwifery might not be apparent to the doctors otherwise. Karen is also "playing the game." She controls the information about what midwives look like and waits to see if the doctors will believe the performance.

Helen, an empirical midwife, relies on an idealized performance and expressive control in her presentation of self:

> Um, I wear as much of the same hat as I possibly can in all settings because I'm a painfully honest person. I have a very difficult time not being sincere about who I am and what I'm doing but, the part that I lost the most was the just plain me part you know that couldn't be, or felt like it wasn't good for midwifery if I ran into a student and their mother in [the grocery store] and you know I'd had a Margarita and so I stink like alcohol, or you know I've got old Birkenstocks and a torn up shirt, you know what I mean. I felt like I had to be kind of "on" almost all the time. And I feel that way anyway. I mean when

> you've delivered 200 babies in one town. I've had it happen literally where you know my friend and I brought the kids to play at McDonalds, this woman kept almost glaring at me in the booth next door, and finally I looked down at her little kids and said that sure is a beautiful boy you've got there. And she said well you should know, you delivered him. So, I feel like I kind of always have to be friendly to everybody because they look mildly familiar, I don't remember if they cut me off in traffic or I delivered their baby sometimes. And that's horrible. (Helen, empirical)

Helen engages in idealization, she feels like she has to "be kind of 'on' almost all the time" in order to present an idealized image of a midwife. To "[run] into a student and her mother in [grocery store]" having "had a Margarita" or wearing "Birkenstocks and a torn up shirt," would be, in Helen's estimation, communication out of character. After describing an incident with a woman at McDonald's, Helen relates her need to use expressive control in all situations: "I feel like I kind of always have to be friendly to everybody."

Changing Public Perception

We have heard midwives discuss what they believe to be the public perception of midwifery and also the ways they present themselves to different segments of the public, the medical community, legislators, and each other. Much of the discussion of public presentation involves an effort to change public perceptions of midwifery. Further suggestions that these women have for changing public perceptions include educating the public and using the media to make midwives more visible. Use of the media would include both advertising and offering positive representations of midwifery and natural childbirth in the popular media.

Educating the Public

I asked these women if the images and perceptions of midwives should be changed and if so, how? One of the most common themes to emerge in response to this question was education, educating the public. Christy, a licensed midwife, comments,

> One thing I'm starting to find is gonna be real important, especially in this state with there becoming more and more midwives, is that when you first start school, or before you start school or whatever, you really should be in your own communities creating the sense, and giving out the information, and inviting people to come hear the information that out of hospital birth is not only safe, it's safer. And just, we really need to work to change the whole way women see birth, because if we don't, we're gonna be scrapping for the same clients, and that's silly. You know, I mean midwifery has to grow. If midwives are gonna grow, midwifery can't grow without people who want them at their births and to do their care. I mean, it will be interesting in 10 years to see what the numbers are in Florida, you know for out of hospital births because it's not gonna happen on its own, it's only gonna happen with education, educating the public. (Christy, LM)

Barbara, also a licensed midwife, expresses sentiments similar to Christy's:

> I think that the midwives that aren't practicing much, they should be talking at least once or twice a week to a small group of women. You know like the tea party kind of situation, they should be at the library, they should be going into churches, they should be going into Sunday schools, they need to be in the schools. If you're not busy, then get your butt out there and talk about birth. Because it has become very warped. People are really afraid of it. So I think that's a big role is to be an educator, because we're the protectors. You can't protect normalcy if everybody's afraid of it, you know you have to like really start talking about what's happening. It would help the movement tremendously if every midwife in every community would commit to teaching once a month even to a small group of people. (Barbara, LM)

Finally, Melanie, a certified nurse-midwife, speaks of educating people about midwifery:

> Just being in the public eye, educating people about what midwifery is. But, I think what we see as our real job is the safeguards of normal birth and educating women and helping women to learn about their bodies. I mean we're really fighting against the huge media, relative, friend kind of onslaught of negative thoughts about birth. (Melanie, CNM)

In each of these narratives, we see the normalizing of birth by those and for those who are involved in the process. Each of these midwives describes the role of the midwife as a keeper, in a sense, of "normal birth." Midwives are givers of information, protectors of normalcy, safeguards of normal birth, and helpers of women to trust their bodies. By giving this description of the job of all midwives, they are establishing their own identities in this way, as educators, as deliverers of self-empowerment for women.

Media and Popular Culture

DeVries et al. (2001) suggest that media plays an important role in influencing the birthing desires of women. The role of popular media was another suggestion the respondents had for changing public perception of midwifery. Listen to Samantha, a certified nurse-midwife's, suggestion:

> But, I wish midwives were represented more in the media. Because like if they had midwives on soap operas delivering babies, maybe there would be more midwives. I think that's a problem where we as an organization are failing to be more of a force in the media and to represent ourselves as what we are, you know professional, trained people that work in and out of hospitals and do a variety of things. (Samantha, CNM)

Samantha begins by referring to the popular culture phenomena of the soap opera, but then shifts her focus to the responsibility of "we as an organization," and here she is referring to the American College of Nurse Midwives, to be more of a force in the media.

In discussing the ideal media representation, she invokes a discourse of education to establish herself and midwives in general as professionals.

Laura, a licensed midwife, also invokes popular culture. Note the differences between Samantha and Laura's use of media as a resource:

> Cindy Crawford had her baby at home with a midwife. It made the front cover of *People* [magazine]. Xena the warrior princess [Lucy Lawless, the actress who plays Xena] gave birth at home in New Zealand, underwater, probably with a midwife, although I haven't seen the reports on that. It's not considered quite such a weird and bizarre thing to do as it was certainly when I was having my kids. I was told it was illegal, it was immoral, isn't that what those hippies in California do? So, it's at least being considered, being talked about. You see it on TV shows, although I would love to see a soap opera have a normal pregnancy and a normal birth. Never to my knowledge does this happen, it's always pre-term triplets in a snowstorm in a deserted cabin. So, that's a media goal, normal birth on a soap opera. (Laura, LM)

While Samantha above cites a lack of representation of midwifery in the media, Laura calls upon the pop culture icons of Cindy Crawford and Lucy Lawless (Xena) to legitimize midwifery and home birth and to establish things as "better than when I was having my kids." Later she refers to the soap opera as the ultimate media goal. Here she contrasts "normal" birth with a high risk, emergency birth as the "norm" in a particular form of media, the soap, that sees women as its primary audience. Presenting this image over and over again in the media perpetuates the medical model of birth as dangerous.

Advertising

A third suggestion for how to change public perception was advertising. Helen discusses how to create a positive perception of midwifery:

> And I've lost touch with what the public might perceive midwives to be. Only in as much as I'm so surrounded by what I think and people around me know because they know me. What I do know is that's what midwives need to do. I think this is a pathetically easy country to market to. I'd like to see billboards. And you know I'd like to see midwifery look much more, I'd like to see health care look much more like what we've got going on in Europe. And it just astounds me that you know our public health folks don't just get brave and take that on, you know because it works, clearly and obviously works. So, I'd like to see the public perception of a midwife be people who deliver babies. I think we need to start working on educational programs for kids. (Helen, empirical)

Helen legitimizes the profession of midwifery by referring to "what we've got going on in Europe." She suggests that for midwifery in this country to be as legitimate as it is in other countries will require marketing, "this is a pathetically easy country to market to," the work of "public health folks," and education programs.

Stella, a direct-entry, student midwife, like Helen, speaks of marketing and education. However, whereas Helen refers to marketing on a national level, Stella plans to target specific communities:

> I just don't think people are informed enough. I don't think, I think we have our job cut out for us, [my business partner] and I have to like do a lot of marketing. I want to sink some bucks into advertising, I just don't think the word is out. I don't think people know what their choices are. I want to tap into the Medicaid community, although they can be borderline high risk clients at times because of their situation, I want, I don't think as consumers women know what their choices are and I want to tell them. I want to, and I see that as a challenge, advertising, educating. I want to target, like there's a large Seventh Day Adventist community in [neighboring community] and I want to target them. Whether that's gonna be a good for us or not I don't know. (Stella, direct-entry student)

In the following exchange, Bridget, a certified nurse-midwife, cites lack of advertising as part of the public's ignorance of midwifery:

Bridget:	And sometimes I think they just haven't got a clue. I think that could be also how our hospital administration chooses not to advertise because we are, as we have heard over the years, you know you can't upset the doctors. We are a threat to the doctors. Why would a hospital in, instead, in my view, why would they want to have someone come in and start delivering, provide prenatal care and deliver babies when there are physicians available? It was because the reimbursement was so poor and the physicians did not choose to have the Medicaid patients in their nice offices. They were to go to the health department. But Medicaid reimbursement is very attractive to the physicians now, they advertise that they want it.
Lara:	So, and you think that advertising midwifery services would really change the public's awareness of . . .
Bridget:	I think so. When I started the practice, you know I was on television and I spoke to different places, and spoke with women's organizations, etc., etc. (Bridget, CNM)

Bridget draws on the tension between midwives and doctors to frame her story of the public's lack of awareness. The hospital does not advertise midwifery services, and to do so would be a "threat to the doctors." She feels that advertising would change the public's awareness and backs this up by referring to the manner in which doctors advertise for specific clientele, and to her own past participation in public relations, "when I started the practice, you know I was on television . . ."

Conclusion

Several months before I began my field work, the novel *Midwives* by Chris Bohjalian (1997) was chosen to be part of Oprah Winfrey's book club. In recent years, this book has been one of the few depictions of midwives in popular culture. I read the novel and enjoyed the story which was a fictional tale of a home birth midwife in rural Vermont who faces a murder trial after she performs an emergency cesarian section on a

woman who she believes to be dead. When I first met the women who would eventually become part of this study, I recalled the novel and wondered what they thought about it. They had mixed reactions. Some thought it was a well-told story, representing home birth midwives fairly accurately, but that the crux of the story, an emergency C-section, was too sensational and unrealistic. Others believed the story to be a negative and potentially harmful depiction of midwives.

Regardless of how they interpret the novel *Midwives,* or whether they believe midwives are positively, negatively, or not at all represented in popular culture, the women in this study have strong opinions about how they are perceived and represented by the general public, the medical community, law makers, and the media. In relating these sentiments, midwives draw upon a variety of legitimations, using discourses of history, alternative medicine, biomedicine, professional organizations, education, and the media to frame their identities. Their discussion of public perceptions of midwives also includes elements of impression management in which they present certain identities to certain audiences depending upon the context and the goals of the interaction.

CHAPTER 8
CONCLUSIONS AND REMAINING QUESTIONS

The leading question in this project is to what extent does the availability of various discourses mediate the stories that midwives tell about who they are and what they do, and to what extent do these women, through narrative, skillfully and artfully construct who they are in relation to their work, the medical community, and the public? There is a certain elasticity to the stories these midwives tell. But, that does not mean that "anything goes." Rather, the elasticity is delimited by available discourses or occupational structures. In Chapters Four and Five we saw midwives from different occupational paths each at a different point in the process of professionalization. Where each stood in relation to professionalization gave rise to a particular narrative form. So, in this case, the structure of the occupations and the discourses available to each shape the stories they tell. Direct-entry midwives, with a few exceptions, have not been trained as nurses and thus do not have a nursing discourse available to them.

In Chapter Six, we noticed midwives framing their identities in a way that coincides with Davis-Floyd et al.'s (forthcoming 2002) description of the postmodern midwife as "know[ing] the limitations and strengths of the bio-medical system and of her own, and mov[ing] fluidly between them to serve the woman she attends" (p. 2). At times midwives uses a discourse of medical collaboration in order to distance themselves from biomedicine and at other times to legitimate their own profession. In a different historical

period, or under different legal or regulatory standards, or different educational requirements, this discourse of collaboration would not be available for midwives to draw from in a discussion of their identities.

Finally, in Chapter Seven, we observed midwives calling up historical images in order to both contrast modern midwifery *and* to embrace a traditional identity. Further, we witnessed different people using the same discourses in different ways, such as invoking the debate over whether or not midwives should be brought together under one political organization to illustrate one midwife's desire to be viewed broadly as a midwife over and above a licensed midwife, and another woman's desire to be viewed as a specific type of midwife above and beyond the more general category of midwife.

Methodological and Procedural Lessons

One dilemma I encountered in my research was the differing types of narratives produced by nurse-midwives and direct-entry midwives. Nurse-midwives, with a few exceptions, seemed to deliver relatively straight-forward, succinct, linear narratives about their life and work. Direct-entry midwives, on the other hand, often told long, complex, semi-linear stories. These stories were much more conducive to the elements of narrative analysis, with narrative resources, narrative frameworks, narrative linkages, and horizons of meaning being more readily identifiable.

In thinking through this dilemma, I speculate that the training that each type of midwife receives influences the way she tells stories about her work. This takes us back to the beginning of the dissertation where Helen, an empirically-trained midwife observes, "I think where you're trained and how you're trained makes a huge difference on how you

practice and where you're comfortable practicing and how you perceive birth." I would add to Helen's observation that where and how one is trained also "makes a huge difference" on how one narrates her work. In other words, nurse-midwives are trained in a university setting, presumably learning that research must follow a deductive, scientific method. Direct-entry midwives have either been trained by apprenticeship or formal education. However, at least in my research context, the formal education of direct-entry midwives has only recently begun to incorporate research methods into the curriculum. I have been instrumental in that process and have introduced inductive and interpretive approaches to research methods along with more traditional deductive approaches.

Bruner (1986, 1996) suggests two different ways of thinking used to make sense of our worlds: paradigmatic and narrative. Paradigmatic thought, claims Bruner, is promoted in science and philosophy and honored in formal education, and "leads to good theory, tight analysis, logical proof, and empirical discovery guided by reasoned hypothesis" (1986:98). Narrative thought, he argues, is the mode of thinking used in literature and in life and "deals with the vicissitudes of human intention" and "leads instead to good stories, gripping drama, believable historical accounts" (1986:98). This distinction fits well with the differences I observed in the narratives of nurse-midwives and direct-entry midwives. I am not certain if the explanation for this difference involves the content of the research or the very process of research itself. In other words, if I were to interview nurse-midwives about some other aspect of their lives, something other than their training and work, would they produce different kinds of narratives? Or perhaps, by presenting myself as a researcher, they assume a deductive research process. This is a

strong possibility. The question, "What is your hypothesis?" was asked of me prior to the interview by almost every nurse-midwife respondent.

This dilemma exists in different ways for other groups as well. A colleague, who is interviewing adolescent males, and I have discussed this issue at length. For him the problem seems to be a developmental one, with adolescents being relatively narratively unsophisticated. Many scholars discuss narrative competence in the context of human development (McAdams 1988, 1993, 1996; Berman 1994; Randall 1995) arguing that it is not until late adolescence that we develop the ability to become "biographers of self" (McAdams 1988). Building on Gardner's (1990) theory of *multiple* intelligences (linguistic, musical, logical-mathematical, bodily-kinesthetic, spatial, interpersonal and intrapersonal) and on Goleman's (1995) idea of "emotional intelligence," Randall (1999) discusses the concept of "narrative intelligence," as "the capacity to formulate a story . . . [and] the capacity to follow a story" (p. 13). Randall (1999) considers narrative intelligence in the context of aging. As we age, our lives become more complicated and "our life-plot thickens" (p. 20) and eventually begins to "narrow" as we approach the end of our lives.

These dilemmas raise interesting questions about narrative practice and narrative analysis with various groups or populations of respondents. Whether we are dealing with people in distinct developmental ages or stages or whether we are dealing with people who have been differently trained or come from atypical backgrounds, we must take into account that different narrative forms will likely emerge. In the case of my dilemma, I

must remember that the lives of nurse-midwives are likely just as complex as those of direct-entry midwives even though, at times, their narratives are not as complex.

Future Projects

There are many substantive issues that I had hoped to include in this dissertation. However, due to time and space restrictions, I have opted to save these for future projects. Among these issues are: 1) identity and emotion management, and 2) identity and social movements.

Building on Hochschild's (1983) innovative work on emotional labor and emotion management among flight attendants and bill collectors, others have discussed these issues within health care professions (James 1992; MacRae 1998; Meerbeau and Page 1998; Olsen and Bone 1998; O'Brien 1994) and have also related emotion work to job satisfaction (Wharton 1993, 1996). Much of my interview data deals with the emotion work and emotion management of midwives. Unlike physicians who are trained to detach emotionally from their patients (Smith and Kleinmann 1989), midwives are trained specifically to emotionally connect with patients. Not only are they engaged in managing their own feelings, but also in managing the emotions of others (Lively 2000; Thoits 1999), including the birthing woman, her support network attending the birth, and other midwives or birth assistants. As they frame their identities in relation to their emotions, midwives draw upon the legitimizing discourses of biomedicine, professionalism, and spirituality, among others.

Another issue that I touched on in this dissertation but would like to expand upon in future work is that of identity and social movements. Following Taylor and Whittier's

(1992) discussion of collective identity within social movements, we see midwives 1) establishing boundaries of identity, 2) raising consciousness particularly through books such as *Spiritual Midwifery* and *Immaculate Deceptions*, and 3) negotiating the boundaries of identity with each other, with the medical community, and with the public. As I discussed in the introduction, identity work and boundary maintenance are issues that are addressed in both the social movements literature and the literature on work and occupations. The nurse-midwives in this study seemed to be engaging in boundary maintenance in primarily an occupational context. On the other hand, direct-entry midwives seemed to move between occupational boundary work and collective action boundary work.

Another issue related to identity within social movements involves generational differences (Mannheim 1952; Schneider 1988; Whittier 1995). The women who were involved in the alternative birth movement and the underground midwifery practice of the 1960s and 1970s often invoked a social movement or collective action discourse in framing their identities. They pointed out, and I noticed, generational differences between this group of women and the women entering the occupation under the current laws. For this second group of women, there is not the same type of collective action sentiment expressed in their narratives. Similar to Broad's (2000) discussion of "momming" engaged in by members of an ally organization to the gay, lesbian, bisexual, transgendered community, and related to generational differences, many of the more established or retired midwives spoke of their role in "midwifing the midwives." Listen as Gina describes this concept:

> But, in general when someone first comes into this program, and especially if they are younger, it's like the beginning of pregnancy, you know they're full of wonder and awe and they have fears and you know they're wondering how am I going to make it through all this. So, the three years is like a long, extended pregnancy. And in that time we give them the training, equal to prenatal exercises, we give them the training that they need to be competent and thoughtful and caring licensed midwives. We try to provide them with a nurturing environment, a small, home-like environment where when you stumble or make mistakes or have to confront your own issues or whatever comes up for you, that we're not like, a lot of times medical programs are about weeding people out. The process is for weeding them out and elimination. And I want the program to be more, that people can be nurtured and work through their fears and their personal growth issues and their academics . . . So, I think we tend to try to help them work through this growth period or prenatal period. Then right about in their senior year, it's like transition and they all start freaking out and they're like I can't do this, I can't believe I'm gonna be a midwife in six more months, and I don't know enough and they get all kinds of fears and all kinds of anxiety going on and they're very scared. And like with a woman in labor, you just reassure her, yes you can do this, yes you do have the experience, yes you have studied hard and your education's served you well, you're gonna make a fabulous midwife. So, we kind of coach them through that transition. And then, generally at the day of graduation and then the final part is when they actually get their license in their hand, we all kind of get teary eyed because now we see a new midwife standing in front of us and it's like the birth of a baby. And this beautiful new being has emerged, ready to become a midwife and take it on. (Gina, empirical)

Implications for Women, Families, and Healthcare

So, why is this important? Why does it matter what the public thinks about midwives? Or how midwives think about collaboration within the medical community? I think there are important implications that affect families, women, and healthcare in this country. I also believe that this type of project, a narrative approach focusing on a small group of women is an important contribution to the larger literature on midwifery and birth. While practitioners, consumers, and public policy makers certainly need large-scale,

representative research on the health outcomes and economic aspects of midwifery in order to make informed decisions, they also need the stories of individual women.

Midwives advocate family-centered care, allowing any family members/friends to be present at the birth and to participate. Women's reproductive rights and choices (which are often associated only with abortion) are at stake when it comes to having the right to choose from various birthing options. Further, midwifery is historically and currently an occupation/profession dominated by women. So, in addition to protecting birth options, this ancient occupation should also be protected for women.

Finally, the World Health Organization recognizes midwives as the appropriate maternity care for most of the world's women. The United States ranks 15th in the world in maternal mortality and 22nd in infant mortality (National Center for Health Statistics 1995). Countries in which midwives are involved in a majority of births have better outcomes for mother and child than the U.S. where midwives are only involved in five percent of births. Also, health care costs surrounding pregnancy and birth could be significantly reduced by incorporating midwifery care more thoroughly into the health care system. Midwives cost less. One local homebirth midwife charges $2,800 which includes childbirth education, prenatal care, and labor and delivery. To birth at a local birth center costs $3,100, also including all aspects of care. In comparison, the base fee at the local hospital is $5,500. This price increases with certain doctors or if special technology is needed.

Giving Back to the Community

To close, in the spirit of feminist research, I feel it is important to point out how this work benefits the midwifery community. I envision midwives using the ideas presented here for recruiting purposes, educational strategies, collaborative efforts, and public relations. Recruiting may be aided by recognizing the diversity among midwives and the variety of entry points into the profession. Educational strategies and collaborative efforts may be strengthened by a continued awareness of the concept of the postmodern midwife who moves easily in and out of a traditional midwifery model and an understanding of a biomedical model. This awareness is likely to also be useful in public relations, educating the public about midwives' education, scope of practice, and willingness to engage in collaboration with medicine, while simultaneously upholding a traditional midwifery philosophy.

APPENDIX
INTERVIEW GUIDE

- Thinking back to when you knew you wanted to be a midwife, or decided to pursue midwifery, or now as you are beginning to pursue this occupation - where were you, what was going on in your life, how old were you, why did you want to become a midwife?
- Once you began training, did any of the ideas change?
- What about now? Why are you still doing it?
- Do you think you'll still be doing this in five or 10 years? (Or what challenges, joys, etc. do you see down the road?)
- Overall were you happy with your training? If it were up to you, what kind of changes would you make?
- Why did you choose CNM over LM (LM over CNM); in your opinion, what is the difference?
- What is the best thing about being a midwife?
- What does it take to be a good midwife?
- Take me through a typical birth.
- Tell me how what you do each day is different from or the same as what a doctor does.
- How is being a midwife different from other work you've done (nursing, childbirth ed, ect.)?

- What's your relationship like with your back-up physician? When you first began in midwifery, what was your attitude toward the medical establishment? Has that changed? And if so, in what direction and why?

- Tell me about your own experience with pregnancy and birth? (If no children - does this affect how you relate to your work or how others perceive you in relation to your work?)

- Do you remember the first time you attended/managed a birth other than your own? Tell me about that experience--how you remember feeling or what you remember thinking?

- Can you talk a little bit about emotions and feelings while you are working, and how you juggle or balance emotions doing the work that you need to do?

- I have heard quite a bit about "burnout." Can you talk about that? Do you have strategies for preventing it?

- What is your favorite "story" related to your work?

- What does your job entail (politics, caregiving, business, public relations, etc.)? And about what percentage of your time would you say is devoted to each aspect?

- Do you belong to any professional organizations? What role do these play in your career?

- Do you consider what you do to be a profession, career, occupation, calling, job . . . . other? And what does that specifically mean to you?

- How do you feel about midwifery education, licensure, and regulation?

- Think about your favorite teachers (mentors)--what makes someone a good teacher?

- How do you decide who would make a good student? What qualities do you look for in students?

- What qualities do you look for in clients--or describe your ideal client?

- How have the clients changed over the years?

- How would you deal with a client who is afraid? In pain? What is your role?
- Do your family and friends support your career? Any problems?
- Is there one book or piece of advice that you value more than others (or use to guide you in your work?)
- What advice would you give to new midwives? New students?
- How do you feel midwives are portrayed or represented in popular culture? Have you read *Midwives* by Chris Bohjalian? What was your reaction?
- Which demographic characteristics, if any, do you think are important for how you relate to your job or understand yourself in relation to your job? Or to how others perceive you in your job? [give list: sex/gender, age, race/ethnicity, religion or spiritual, education, sexual identity, social class background or current, relationship status (married, single, divorced, cohabiting, etc.), parental status, anything else].

For retired midwives:

- Why are you no longer practicing midwifery?
- What has the transition been like? What kinds of adjustments have you had to make?
- Do you think you'd ever go back?

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BIOGRAPHICAL SKETCH

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I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

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I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Constance L. Shehan
Professor of Sociology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Hernán Vera
Professor of Sociology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

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This dissertation was submitted to the Graduate Faculty of the Department of Sociology in the College of Liberal Arts and Sciences and to the Graduate School and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy

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Dean, Graduate School